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the JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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JANUARY 1968
VOL. 65, No. 1

ANNUAL MEETING — May 18-22, 1968
Haddon Hall, Atlantic City

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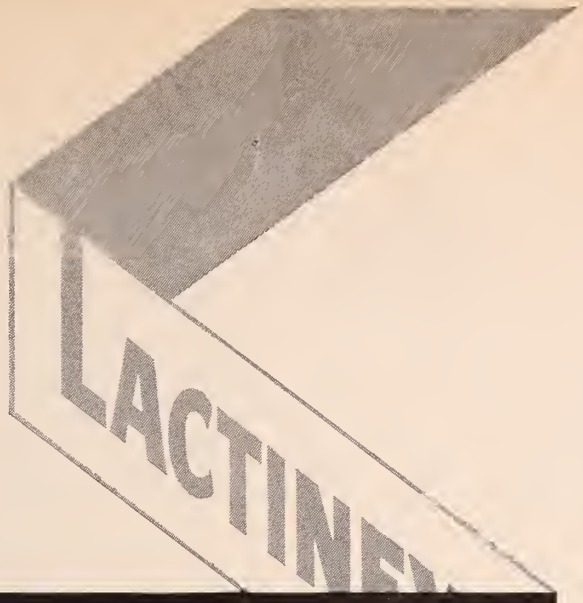
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THE JOURNAL is published monthly (since 1904) by The Medical Society of New Jersey — under the direction of the Publication Committee — 315 West State Street, Trenton, New Jersey. Phone: 394-3154 (Area Code 609); Printed and Published at Periodical Press, 3rd and Hunting Park Avenues, Philadelphia, Pennsylvania.

SUBSCRIPTION RATES — Price per year in advance, including postage: United States, $5. Foreign, $5, plus postage.

SINGLE COPIES—50 cents each. If more than two years old, $1 each.

Second-class postage paid at Philadelphia. Address all communications for publication to P. O. Box 904, Trenton, New Jersey 08605.

EACH MEMBER of the Society is entitled to receive a copy of THE JOURNAL every month. Whole number of issues 761.

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Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

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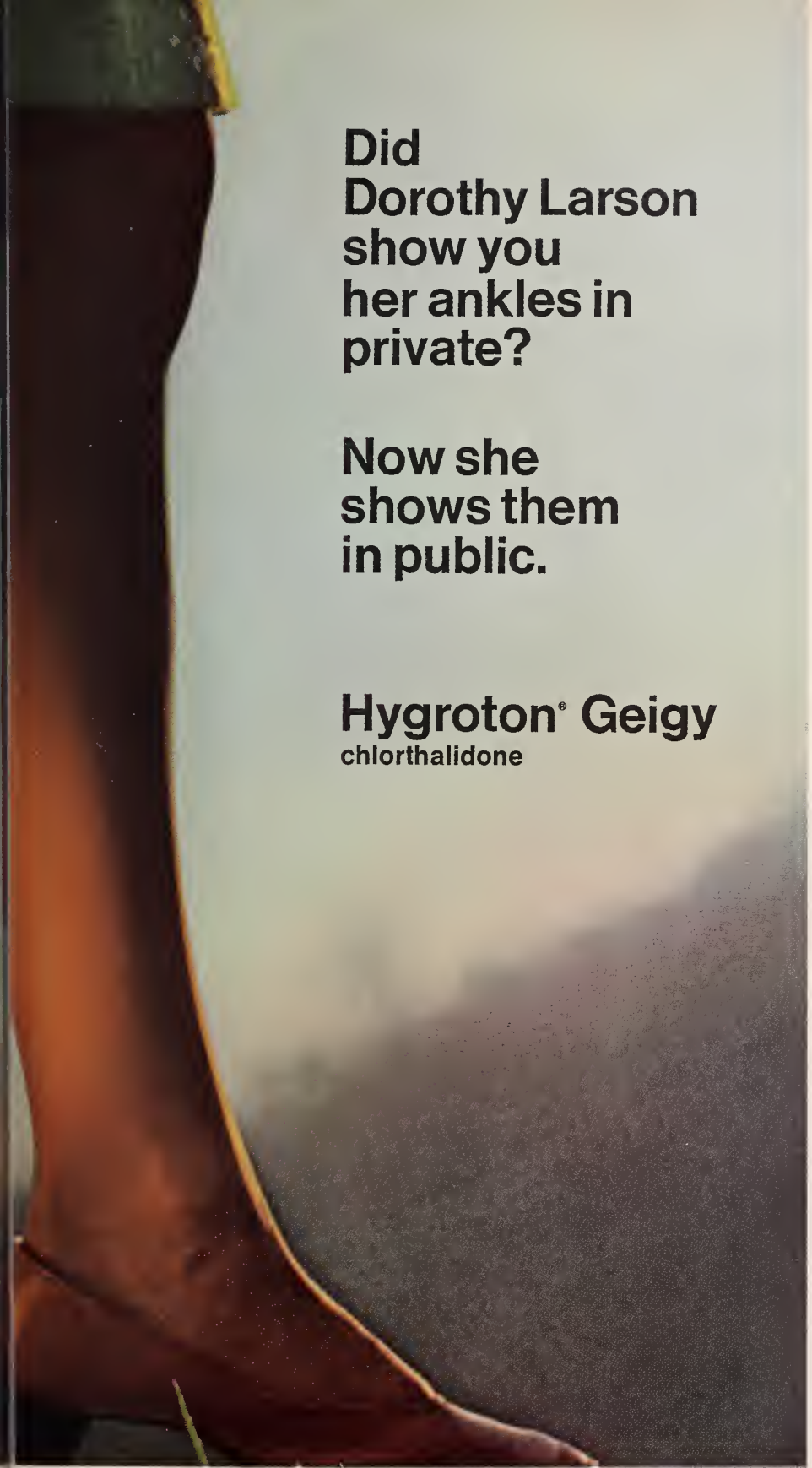
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Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Be
cause of the possibility of prog
sion of renal damage, periodic
determination of the BUN is ind
cated. Discontinue if the BUN ri
or liver dysfunction is aggravate
Hepatic coma may be precipitat
Electrolyte imbalance, sodium a
or potassium depletion may occ
If potassium depletion should o
cur during therapy, Hygroton sh
be discontinued and potassium
supplements given, provided th



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Hygroton therapy may mean troublesome side effects for some patients. A summary of the prescribing information is shown below.

nt does not have marked oli-
.
special care in cirrhosis or
e ischemic heart disease and
tients receiving corticoste-
, ACTH, or digitalis. Salt re-
ion is not recommended.
rse Reactions: Nausea, gastric
ion, vomiting, anorexia, con-
tion and cramping, dizziness,
ness, restlessness, hyperglyc-
a, hyperuricemia, headache,
le cramps, orthostatic hypo-tension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.
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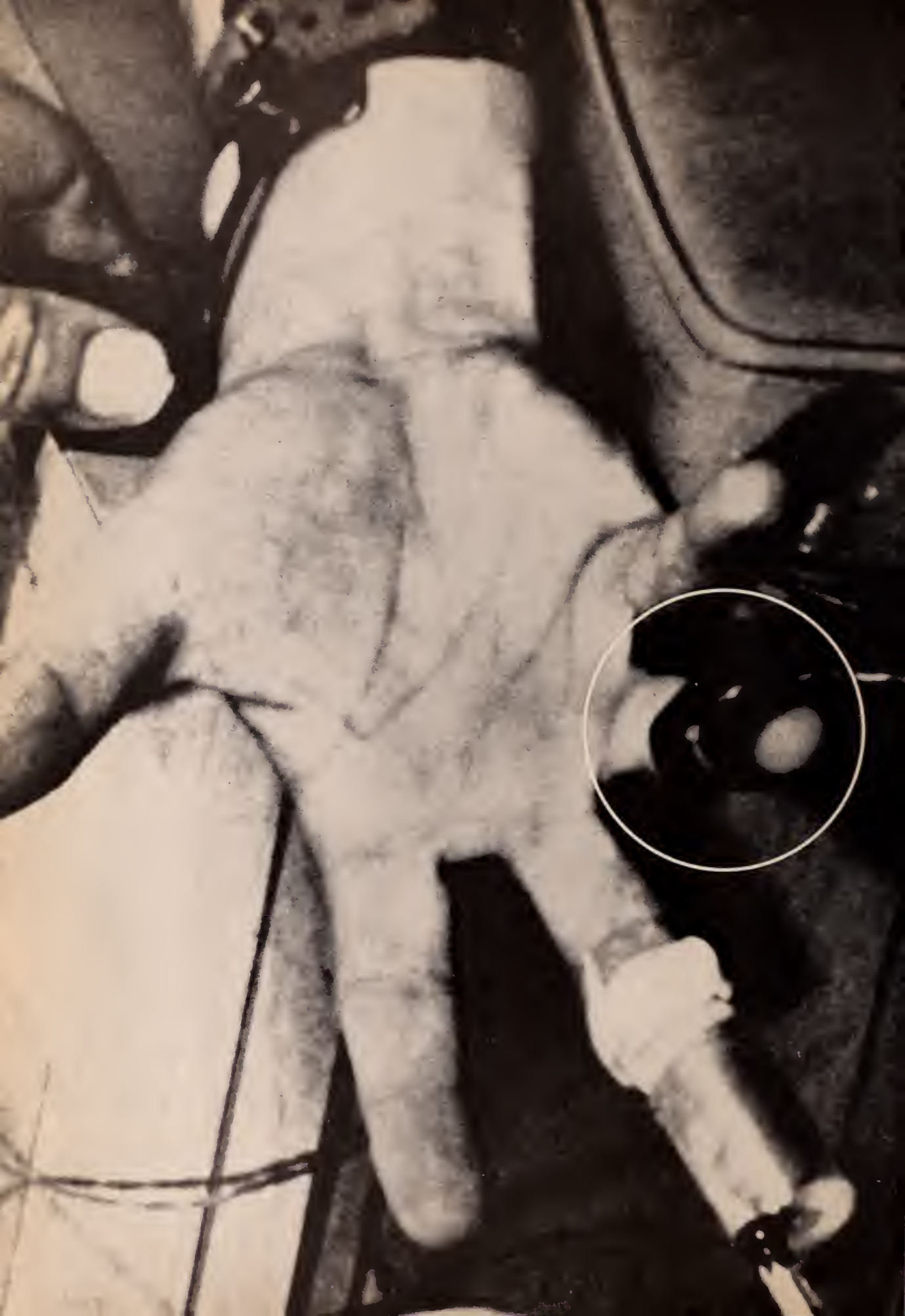
The invitation accompanies the personal Schedule of Fees as submitted by the doctor. Any fees which exceed the 90th percentile . . . the range which accommodates the usual charges of 90 percent of the doctors surveyed . . . are indicated, with an explanation of how the doctor still may participate. A Special Participating Doctor Agreement is scheduled.

The Plan urges every doctor receiving such an invitation, to enroll as a Participating Doctor in Prevailing Fee Programs; this is not related in any way to participation or non-participation in other Blue Shield programs.

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Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with a history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—*Adults:* Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See *Precautions.*)

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Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidenc in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast change (tenderness, enlargement and secretion), change in weight (increas or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstruallike syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, and itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

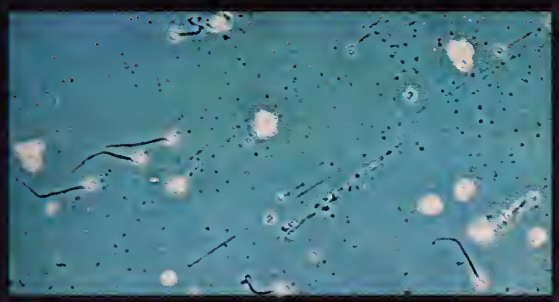
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

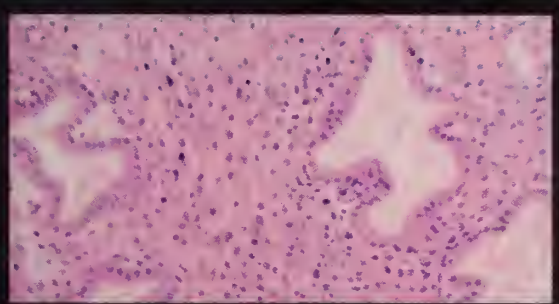
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

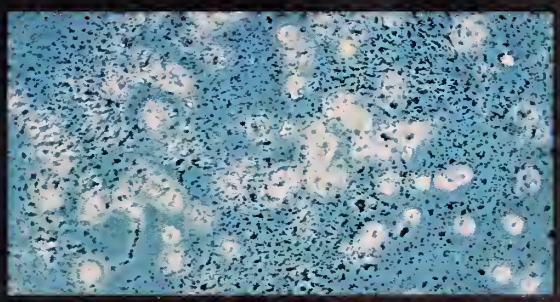


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

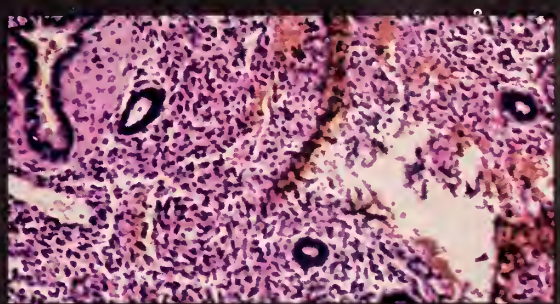
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1 tablets
(norethindrone 1mg. & mestranol 0.05mg.)

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the "economy" of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar®
fluocinolone acetonide





For everyday topical steroid therapy

Synalar® 0.01%

fluocinolone acetonide provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

fluocinolone acetonide — an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.





"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



in moderate hypertension and
poorly controlled mild hypertension
(when diuretics or sedatives are inadequate, for example)



When your patients expect a lot...

like relief from hypertensive symptoms
(headache, fatigue, nervousness, palpitation or insomnia, for example)

like an up-to-date, once-a-day dosage schedule
(a schedule not unlike timed-release medication, for example)

like a daily dose of medication for peanuts
(at 10¢ a tablet, for example)

like generally well-tolerated therapy
(as described in the package insert, for example)

...give them a little
(one tablet daily)

Regroton®

chlorthalidone 50 mg., reserpine 0.25 mg.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Regroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-B
For details, see complete Prescribing Information.

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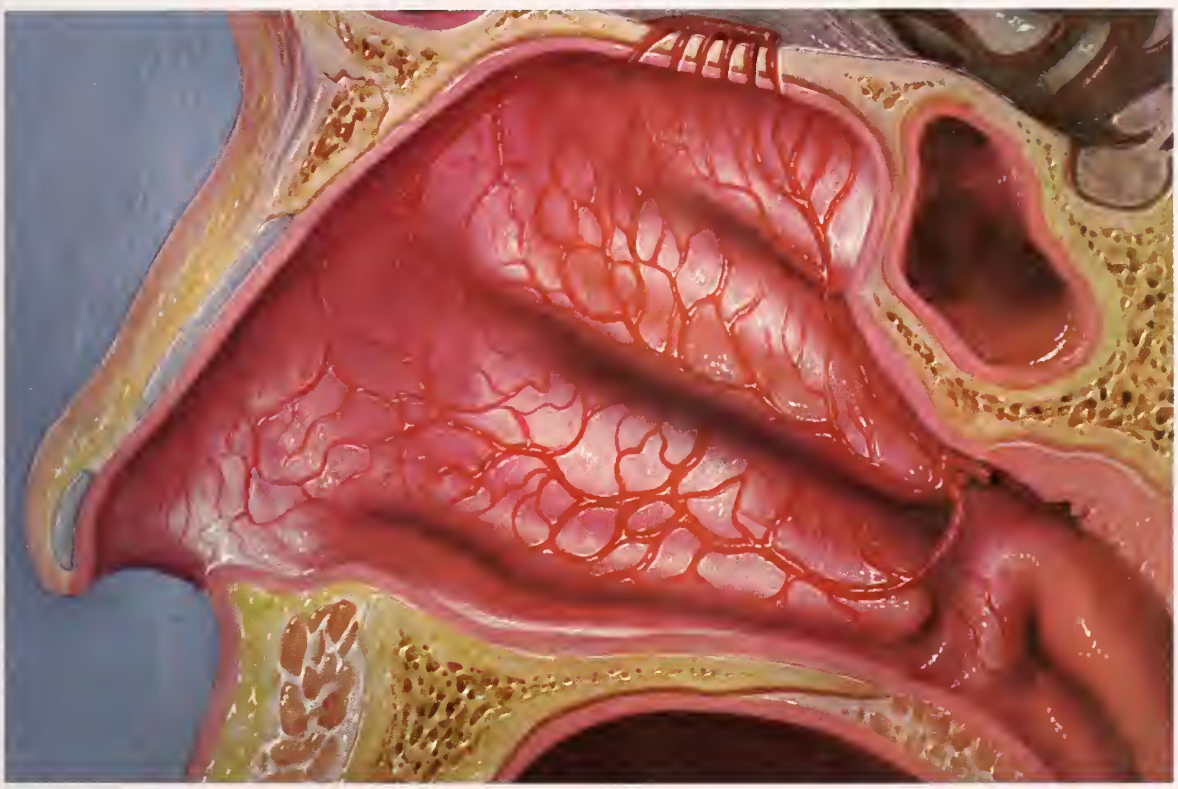




winter 1968

DORSEY Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska 68501. Address communications to Keith W. Sehnert, M.D., Medical Director.





this issue: the cold in pregnancy...

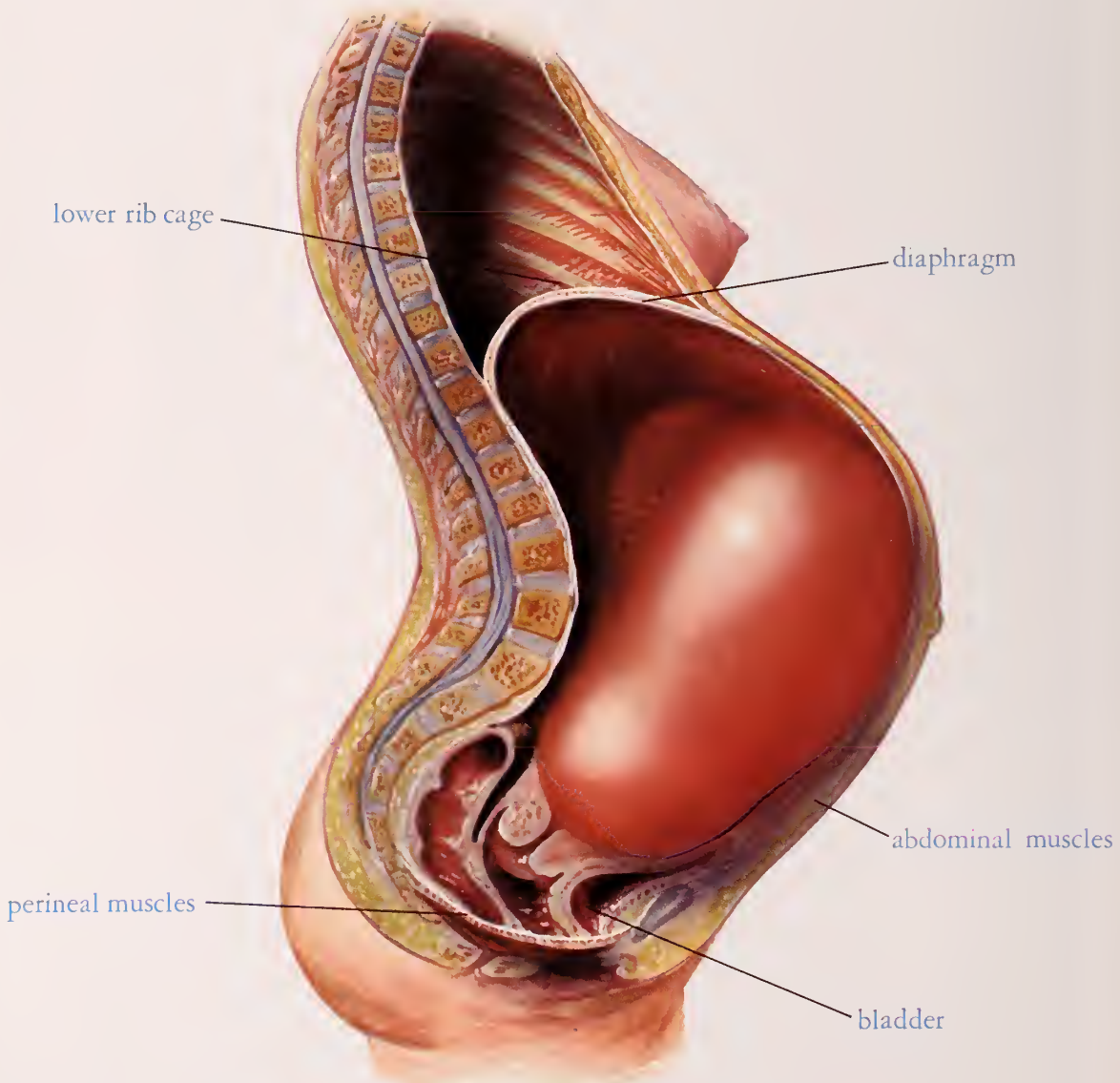
the cold in pregnancy

Frederick W. Goodrich, Jr., M.D.
Senior Obstetrician and Gynecologist, Lawrence and Memorial Hospital, New London, Connecticut

Since pregnancy and the common cold are both ubiquitous, it is not surprising that they often occur at the same time in the same patient. Incidence figures are hard to come by, but the chances are very good that any given pregnant woman will have a cold at some time during the nine months of her gestation. When she does, she will tell you that it is the worst cold she ever had. It seems to last longer and the symptoms are more distressing than they are in the non-pregnant.

For purposes of this discussion, the common cold is considered to be the well-known symptom complex which includes sore throat, stuffy nose, and a cough. Febrile states or extension of the disease process into the lower respiratory tree are not part of the common cold and will not be included in this discussion.

The clinical picture of a cold in pregnancy can be confused by a long-known physiological phenome-



non. Kiesselbach's area in the nose (on the anterior part of the nasal septum above the intermaxillary bone) becomes engorged, apparently due to hyperemia induced by the increased estrogen level which accompanies pregnancy. The amount of congestion can vary in degree from woman to woman. Some have very little congestion, others will have occasional nosebleeds from this area, still others will have symptomatic congestion to the degree that they will complain of having a "chronic" or constant cold.

less well recognized is the occurrence of this type of hyperemia in any part of the nasopharyngeal mucosa, again in varying degree. Such swelling often produces a postnasal drip which, the patient will state, is present only when she is pregnant. Patients who do not have symptomatic congestion ordinarily, will find that when they do get a cold, the symptoms last much longer than those of a cold usually do. Occasionally, this hyperemia is responsible for closure of the medial end of the Eustachian tube; such patients will complain of "plugging" of the ears. Inspection of the ear drum will show a depression which confirms the presence of Eustachian closure rather than wax in the canal which is the patient's diagnosis. Symptoms related to this physiological congestion are more apt to occur in heavier smokers or those who have a history of allergic rhinitis, just as are the symptoms of the common cold. And when the cold does occur in pregnancy, the symptoms are worse because of the underlying congestion.

The pregnant woman with a cold is miserable for other reasons, dependent somewhat on her parity and the length of her gestation. As parity increases, so also does the relaxation of the abdominal and perineal musculature. The uterus, lying against a slack abdominal wall, and bearing down on relaxed perineal muscles, acts like a piston when the patient coughs, sneezes, or even blows her nose, pushing down on the bladder. Stress incontinence during colds is almost the rule.

As the length of gestation increases, so does the size of the uterus. As it grows, it pushes the abdominal contents above it and elevates the diaphragm. This results eventually in a lateral displacement of the lower rib cage, often to a point at which the patient will complain of soreness in this area. If such a

(Concluded on following page)

From a continuing study on nasal congestion...



timed to work while your patient does

A study begun in 1966 by the Department of Otolaryngology, Greater Baltimore Medical Center, has accumulated evidence that documents the effectiveness of Triaminic's timed-release action in the treatment of nasal congestion.

With its balanced formulation of an oral nasal decongestant and two antihistamines, Triaminic effected partial or complete relief in more than 82% of the 85 subjects treated. Clearing nasal obstruction. Reducing turbinate swelling. Making breathing easier.

It's a comforting thing to know that Triaminic really works.

Triaminic® *timed-release tablets*

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50mg.
Pyrilamine maleate	25mg.
Pheniramine maleate	25mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)

patient has a cold, the coughing and sneezing will exaggerate this soreness. The diaphragmatic restriction caused by the enlarging uterus also makes breathing more difficult, particularly when the patient lies down. A cold compounds this difficulty.

Treating a cold in pregnancy requires two additional considerations. The patient should be told that the symptoms may last longer lest she become discouraged, and she should be reassured that the treatment will not damage the fetus. Although there are still some women who seem blissfully ignorant regarding matters of health (and these need to be cautioned not to take medication recommended by friends), most of our maternity patients are aware of the thalidomide tragedy. These women need constant reassurance that the symptoms of a cold can be treated, and that the medication is safe. Fortunately, many of the drugs which are of benefit have been in use long enough and widely enough so that such a statement can be offered. Occasionally one encounters a patient who is so anxious to avoid medication that she is extremely reluctant to take anything at all. Since cold is self-limited, it seems reasonable enough to give such a patient the choice and not to force drugs on her if she is obviously afraid of taking them.

The most distressing symptom of the common cold is the nasal congestion. This can be mitigated by the use of a decongestant which will help reduce the postnasal drip and the coughing caused by it. The kind of a cough which is described as a "tickling" in the throat and which is apt to occur when the patient goes to bed is usually due to nasopharyngeal congestion rather than inflammation in the lower respiratory tract.

There are many cough mixtures available. Most contain an antihistamine, a decongestant, and a cough "suppressant." Should cough suppression be desirable, it is important to remember not to use both a decongestant tablet and such a cough mixture as the patient would be getting a double dose of the decongestant. With some patients, the placebo effect of a cough syrup may be important and a liquid preparation might be substituted for an oral tablet.

For a sore throat, candy drops or lozenges at frequent intervals are soothing. It is not only unnecessary but unwise to use antibiotic lozenges or drops. The use of antibiotics in an uncomplicated cold is contraindicated and should be scrupulously avoided.

In summary, a cold in pregnancy is more severe and longer lasting. The treatment of the symptoms with local and systemic decongestants will make the patient more comfortable.

Apparently the cold is so common in pregnancy that it has received very little attention in the literature. References are almost non-existent and the few which are available add little to the common knowledge, are out-dated, or are not helpful. Thus the usual bibliography is not appended.



Relieve his sniffles, her concern, and about half your phone calls. Tell her to get "The Orange Medicine"



Triaminic® syrup

Each teaspoonful (5 ml.) contains:

Phenylpropanolamine hydrochloride	12.5 mg.
Pheniramine maleate	6.25 mg.
Pyrilamine maleate	6.25 mg.

For nasal congestion you can bring quick, lasting comfort to your little patients with Triaminic Syrup. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

(Advertisement)



Phenaphen with Codeine

the only leading compound analgesic that calms instead of caffeinates

Each capsule contains:

Phenobarbital (¼ gr.) ..... 16.2 mg.
(Warning: may be habit forming)
Aspirin (2½ gr.) .....162.0 mg.
Phenacetin (3 gr.) .....194.0 mg.
Hyoscyamine sulfate .....0.031 mg.
Codeine phosphate.....¼ gr. (No. 2), ½ gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)

Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

A-H-ROBINS

A. H. ROBINS CO., INC., Richmond, Va. 23220

When the agitated businessman goes to work...

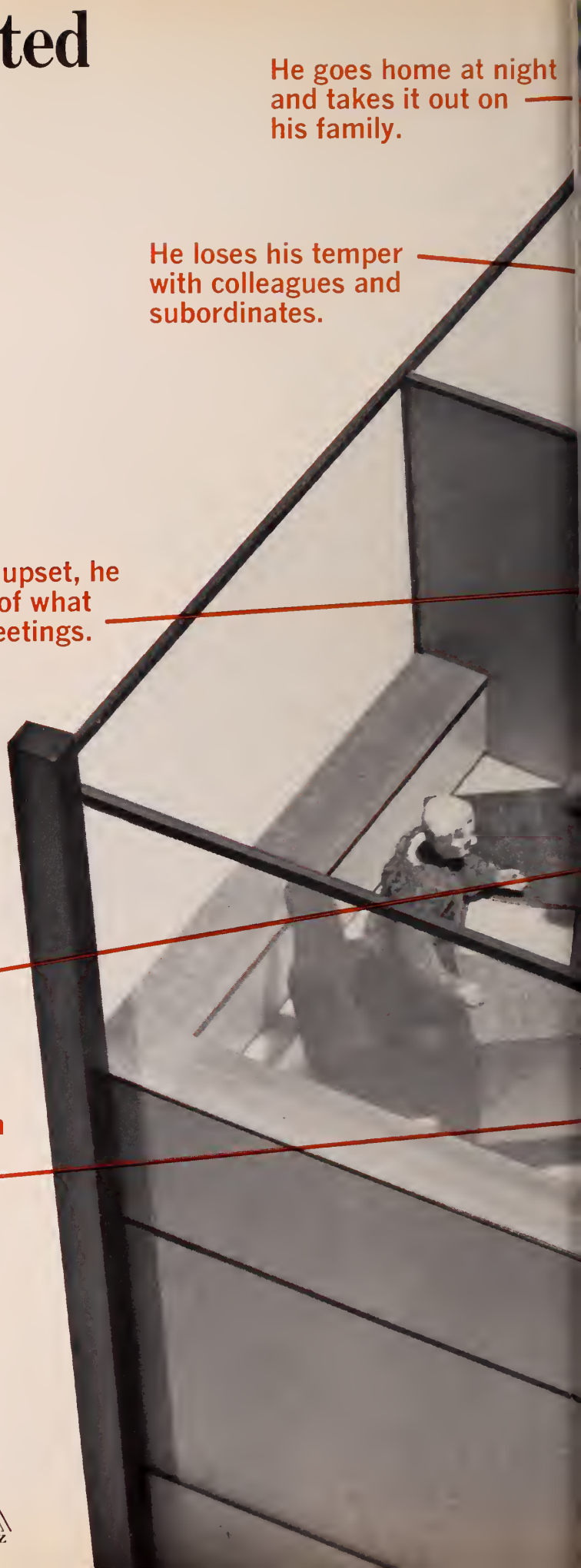
He goes home at night and takes it out on his family.

He loses his temper with colleagues and subordinates.

Emotionally upset, he misses half of what is said at meetings.

He is always fearful about his standing with the boss.

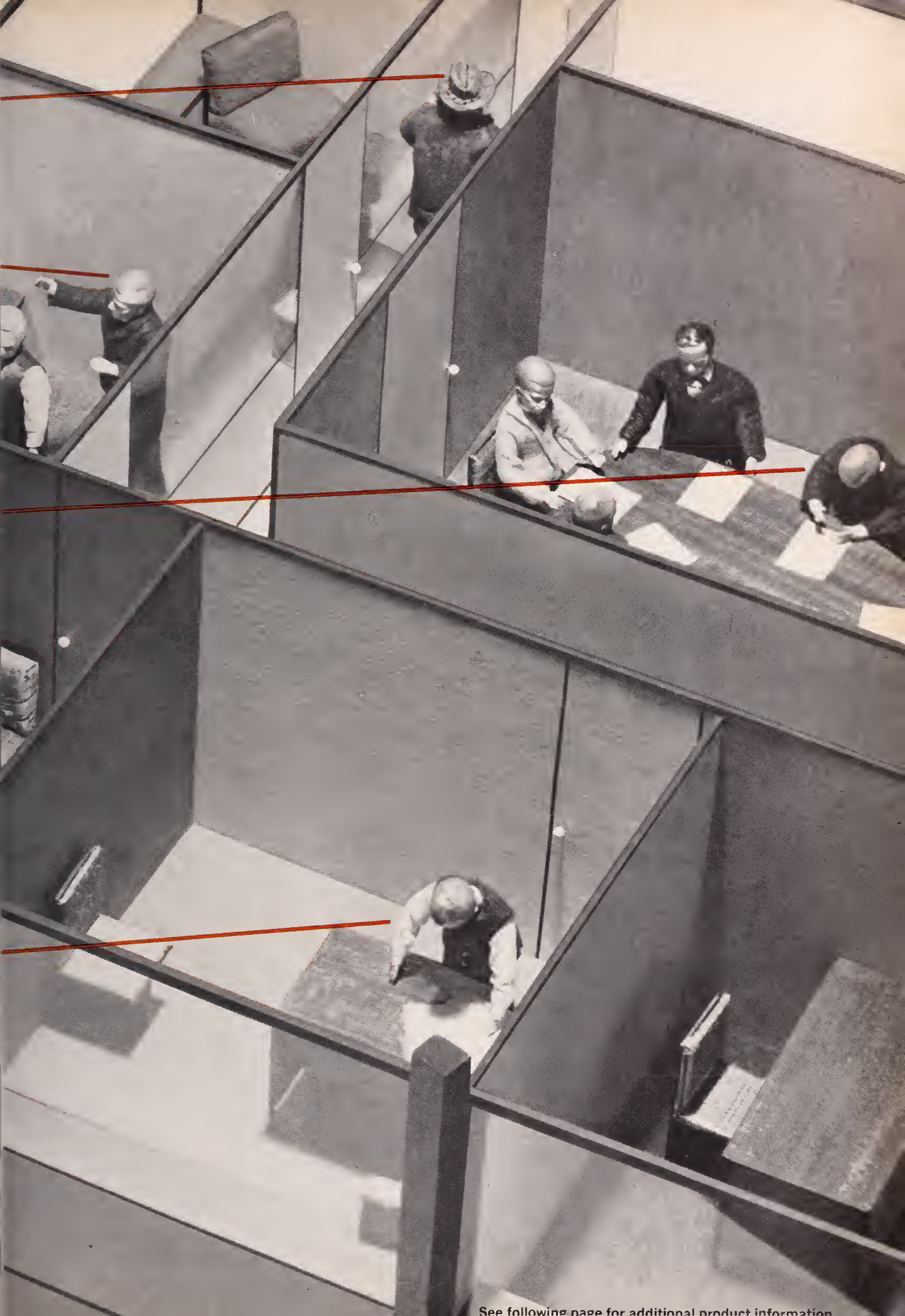
He just can't seem to settle down to his work.



for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ



See following page for additional product information

When the agitated businessman goes to work...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
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Manufacturers of ethical pharmaceuticals since 1856

If hypothyroidism leaves your patient feeling like this...

consider

LETTER®

(SODIUM LEVOTHYROXINE, ARMOUR) TABLETS

Synthetic Thyroid Replacement Therapy



Letter® provides all the advantages of the synthetically pure chemical sodium levothyroxine. Dosage is precise and potency is consistently uniform.

and

Letter® is micronized to provide maximum opportunity for full absorption and clinical response.

In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

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in alcoholism:

B and C vitamins aid therapy. Therapeutic amounts of B and C vitamins can be important in the management of the alcoholic patient. In alcoholism, as in many chronic illnesses, STRESSCAPS vitamins aid therapy.



Stresscaps®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
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EDITORIALS

All The Drowsy Syrups Of The World

Every second American, according to a Gallup poll, has trouble falling asleep. At least, every second American *thinks* he has such trouble—and that's practically the same thing. It has been authoritatively estimated that insomnia is the third commonest of all medical complaints—being outnumbered only by pain and anxiety. Since pain prevents sleep, and anxiety is often the fruit of insomnia, it may be said that sleeplessness comes close to being the number one complaint in all medicine. Modell says that Americans swallow about two and a half million doses of barbiturates every day. If half of these are intended to facilitate sleep (surely a conservative estimate) it would seem that more than a million of our fellow-citizens suffer from insomnia.

Insomnia is terrifying to all but the most philosophical. Minutes are stretched into hours, and the darkness clothes our thoughts with somberness. The harder one tries to sleep, the tenser he becomes. The more tension, the less sleep. In every other activity, it is sound advice to strive, to try hard and to go in there punching. But not when one is courting sleep. No emperor can buy a moment's natural sleep for all the gold in his coffers. The poorest beggar may enjoy a boon denied his emperor. Once he does get to sleep, there is no difference between the king and the slave.

It is a common grievance that whatever you like is bad for you. This is the complaint that attaches itself to the pleasures of wine, women, and gluttony. But sleep is an exception. Here, at last, is one thing people like—that is truly good for them.

Sleep should be the easiest of all processes to investigate. Every one is asleep a third or a fourth of his life, and people for study are all around us. In spite of the accessibility of subjects, sleep's mystery remains unsolved.

Studies have been made of persistent forced sleeplessness. Compulsory vigil produces hallucinations, amnesia, and various schizoid symptoms. This is true even if the subject rests and relaxes. The magic, it seems, lies in the impairment of consciousness. There are reams of literature about the physiologic concomitants of sleep—the slower heart rate, the lowered body temperature, the drop in blood pressure, and minimization of muscle tone, the reduction in metabolism generally. But these tell us nothing of the inner experience, the flight from conscious contact with reality. The electro-encephalogram shows distinctive brain wave patterns in sleep. Very pretty tracings are produced and they differ from tracings in the waking state. These tracings paint a pictorial cryptogram of brain action. But no one has found the key to the cryptogram.

How does the body accomplish this nightly miracle? Some say it is a matter of cerebral anemia—a fine theory, except for the fact that the brain gains blood volume during sleep. Maybe though, that blood is less well oxygenated. Or maybe the brain gains blood as a whole because certain parts of that organ are drained of blood. If you don't like that theory, how about the fatigue toxin? A tired man feels toxic, and perhaps fatigue sends poisons into the brain. Or, could it be that neurones withdraw from each other, and these briefly broken synapses interrupt cerebral function? Or maybe sleep is simply the end of a chain of reflex inhibitions resulting from over-stimulation: a kind of conditioned reflex mechanism.

Perhaps we are approaching this the wrong way. Sleep is such a boon that we try to find what causes it. But let us look at it the other way. The remarkable thing is not that we sleep but that we stay awake. Nathaniel Kleitman, indeed, has it that there is a special diencephalic center—not, if you please, a sleep center, but rather a wake center. This stays in action because it is constantly bombarded with impulses. When this process stops—when muscles tire, the room darkens, attention flags, noise is softened, when all this happens, the

wake center is no longer stimulated and finally it suspends operations for the night. And then the normal state of sleep takes over.

How to induce sleep? You can take a warm bath, buy a noise absorbing box, lie on an especially hard—or especially soft—mattress. You can count sheep, lie on your right side, take barbiturates, do without a pillow, or try an especially big pillow. You can use ear plugs or drink hot milk. You have indeed, a mad choice of frenzied activity by which you can woo this unreliable goddess. Unhappily, the more feverish the activity, the less successful the wooing.

Sleep is an essential of life, yet, as Homer writes, it is the twin of death. Sleep is needed to make us healthy, and presumably without health there is no wealth. So sleep, in one sense, leads to prosperity. But *Proverbs* warns, "Love not sleep lest thou come to poverty" and Poor Richard admonishes: "Up, sluggard; waste not of life: the grave will be sleeping enough."

Sleep is associated with pleasant passivity; yet when followed by the preposition "with," it is also a symbol of pleasant activity. This curious association of sex and sedatives lends yet another dimension to sleep. One is here reminded of Judge Donahue's dictum when he ruled that *Forever Amber* could be sold in Massachusetts. "This book," he wrote, "acts like a soporific not like an aphrodisiac. While conducive to sleep, it is not conducive to desire to sleep with a member of the opposite sex."

Throughout the world, pharmaceutical companies are toiling to find the perfect hypnotic —to make what Shakespeare called one of "the drowsy syrups of the world." The opiates have had their day—or night—as bringers of the balm; and then came the bromides, latterly the barbiturates, and now a rainbow of tranquilizers, soothers, soporifics, and sedatives. Each new drug is hailed with the most flattering of all claims: that it closely imitates nature, producing "natural" sleep. Relentlessly the search for the perfect soporific is pressed. Some day it may lead to a wonder drug that will copy natural sleep even as a formula copies mother's milk.

Everywhere, every day a patient poignantly pleads with his doctor to bring sleep into his nights. The cry is for that sleep which "knits up the ravelled sleeve of care." Or as Philip Sidney so gracefully puts it:

". . . that certain knot of peace.
The baiting place of wit, the balm of woe
The poor man's wealth, the prisoner's release,
Indifferent judge between the high and low . . ."

It is so easy to prescribe the newest sedative. It takes little of the doctor's time—a scrawl on an Rx blank and it's done. And there is always the detail man to tell you how to spell the trade-name and how it is packaged. Yet half the time the insomnia is but a paraphrased anxiety—an anxiety that yields to understanding, to unhurried conversation, to help in teaching calm and relaxation. This is the greater boon, if we but had the time to confer it on all our patients. But this tense world makes insomniacs of many of us, and creates an age of anxiety. Perhaps as Nathaniel Hawthorne said just 100 years ago: "The world should recline its vast head on the first convenient pillow and take a long, long nap."

With Their Boots On

One of the major reasons for the AMA's question about social security for MDs is the fact that so few physicians retire at age 65. A recent study shows that there are now some 23,000 physicians in the country between the ages of 65 and 74. And of these, 19,000 are still in active practice. That amounts to 84 per cent. And we all know some over the age of 74 who are engaged in vigorous and valuable medical activities. Actually, the effective ratio of over-65 doctors in practice is even higher than the indicated 84 per cent, because the "not-in-practice" group includes a great many women physicians who had become housewives many years ago, plus a fair number who were actively working, but employed on salary.

One wonders whether any other profession can boast of so long a span of active service. The trend is the other way around: toward earlier retirement. The traditional "30 year service" prerequisite for retirement was generous enough because many entered the profession, the trade, or the craft at age 25 or 26. But now there is talk of 25 year service prerequisites. It has opened up new fields in providing activities, interests, and entertainment for retired people in their 50's and 60's.

In medicine, however, that trend is not noticeable. The replacement of the horse and buggy by the automobile, and the waning of house calls, have combined to reduce the physical load on the doctor. Much medicine today is practiced at the desk, looking at x-ray and laboratory reports, writing notes, or filling out forms. The physician of 70 who has preserved his clarity, becomes a shrewd, experienced and highly valued medical practitioner.

In private practice there is no supervisor to tell you when to retire, no time clerk to toll off the years and announce that your hour has come. Sometimes an Alzheimer's Disease makes itself apparent to the observer, if not to the victim. And so, the doctor — whether rambling in his anecdotage or whether sparkling with wit and keenness, keeps plugging until one day he dies. With his boots on. And perhaps that's the way we all really want it.

A Kind Word For The Care Of The Crock

Chronic diseases are not nearly as interesting as acute ones. The adjective "chronic," gracelessly shortened to "crock," is indeed a pejorative one. As a result, hospitals for chronic illness are often downgraded to the point where they aren't even considered hospitals. They are nursing homes, convalescent homes, boarding homes, or even "extended care facilities." Some of them, in spite of this stigma, are wonderful. But most such institutions tolerate standards that would not be acceptable in a general hospital.

Every speciality is now so complex that we have to have subspecialties. There are internists who do only gastroenterology and others who do only cardiology. Allergic disorders represent a subspeciality within pediatrics or internal medicine. General surgeons have largely abandoned fracture work to orthopedists and are willing to let gynecologists do the hysterectomies. The child psychiatrist hesitates to treat an adult. And so it goes.

The trouble is that the chronically ill person is also complex. He is bound to suffer from multiple disabilities so that the need for all-around patient care is obvious. Such a patient calls on even greater medical skills than are required in more concentrated, single-syndrome diseases.

Any advance in this area requires that the physician have access to a large pool of patients. But the only place where such a pool can be found is in the chronic disease hospital. It may be that we can escalate the standards of such institutions by fiat; by using existing accreditation, certification, and chartering mechanisms. Or it might be better to have a chronic unit as part of a large hospital complex. But one thing is sure. The chronic department must have interested practitioners, must attract graduate and undergraduate students, must offer teaching facilities, must encourage research (certainly their patients represent a gold-mine of research possibilities), and must find room for all therapists who can contribute to the care of the chronically ill.

The spectacular medical and surgical advances of the last half-century have been largely in the field of acute and infectious disorders. The care of chronic illness has been the target of much adverse criticism. We have reached a point where most deaths are from cardiovascular disease or malignancies. It is time to shift attention now to the less glamorous, much neglected "chronic" sector of patient illness.

ORIGINAL ARTICLES

As educated and involved citizens, doctors will be interested in this brief account of a little-known subject that may spell survival for us all.

Portal To Another World*

Louis K. Collins, M.D./Glassboro

I bring you hearty greetings from The Medical Society of New Jersey and wish you well in all your endeavors this year. You are our eyes and ears, our thoughts and words, and you certainly help to make or break our image with the public. I am sure you realize that in more ways than one we cannot get along without you.

Today, I shall digress from the usual format in these meetings, and tell you of a most unusual and vitally interesting, non-medical experience, in which I most fortunately participated recently. This was a tour, sponsored by the New Jersey National Guard, to inspect the Air Defenses of the United States. This "Operation Understanding" took us to Fort Sill, Oklahoma, the home of the Army Artillery and Missile Center; to Fort Bliss, Texas, site of the Army Air Defense Center and the Army Air Defense School, including McGregor Firing Range; to White Sands Missile Range, New Mexico; and to Headquarters of the Army Air Defense Command at Colorado Springs. In Colorado Springs we also visited the beautiful Air Force Academy, with its unusual Chapel. Highlight of the trip was an inspection of NORAD (North American Air Defense Command) in its Cheyenne Mountain Complex.

Man may have completed an evolutionary cycle in his fight to survive in a hostile world — he's back in a cave. A small, modern community has been hollowed out of a 100-million-year-old mountain near Colorado Springs. It is completely defensive in nature, designed to give maximum protection to a small group of people whose tremendous task is directing a possible future battle in aerospace defense of the North American continent. At the heart of this complex is the North American Air Defense Command's combat operations center. Tactical control of the continent's air defense is directed from here. Vital communications systems, so necessary to modern defense, are also housed in this mountain.

Granted access at the 7,000-foot entrance, the one-third mile trip into the tunnel is nothing unusual, until you suddenly face a 30-ton steel blast door. This is the portal to another world. There are two of these doors, 50 feet apart, with an electronic system that insures that one door is always closed. Eleven buildings make up this city deep within Cheyenne Mountain. These two and three story buildings constructed of ⅜ inch welded steel plates, are mounted on coil springs of three inch diameter rods, which act in concert with hydraulic shock absorbers.

The installation includes a modern medical facility with a dental office, an operating room, pharmacy, x-ray, and a small ward for the 425 people at work. In an emergency, a staff of 900 can be accommodated and remain self-sufficient for a month. The planning, the engineering feats, the construction, the air conditioning, the reservoirs, and the power plant are stories unto themselves.

* Talk delivered to the "workshop" of the The Woman's Auxiliary to The Medical Society of New Jersey, assembled in Trenton, October 30, 1967. Dr. Collins had been one of a group invited to be guests of the New Jersey National Guard on a tour of our Air Defense installations.

We had many briefings throughout our tour. These concerned not only the defense of our country, but also told us of, and showel us, a parade of modern weapons utilized in offense: artillery, missiles, rockets, and the like.

The speed with which these could be transported, assembled, and prepared for firing was a revelation. We witnessed the actual firing of the Nike and Hawk missiles at the McGregor range aimed at simulated and actual targets. Many of the longer missiles land at White Sands, and here a visit to the missile graveyard was quite illuminating.

We are in the New York-Philadelphia Defense area, and are protected by probably the highest concentration of Nike bases in the world. We saw a full scale demonstration of a crew in action, first slowly for our edification, and then at normal speed which would be used in an actual firing. About one third of the sites in New Jersey are efficiently manned by our National Guard. Here in our state, we should feel pretty safe from attack by hostile aircraft. The Nike-Hercules guided missile, with a range of more than 75 nautical miles, supersonic speed, ceiling above 150,000 feet, has a two-stage solid propellant, weighs 10,000 pounds at launch, is 41 feet long, and can carry either a conventional or a nuclear warhead. For lower flying aircraft, we have operational the Hawk Missile, accurate from 100 to 38,000 feet.

As was announced recently, we are developing a capability against ICBM's to be installed in the west facing China. These will be the Nike X which must be faster than the ICBM's, with a sophisticated radar and guidance system that can intercept the target long before it is near our shores.

For security reasons, we were not able to see most of the rooms within NORAD in Cheyenne Mountain. However, the briefing and description were impressive. Some of the highlights that I remember are as follows:

1. Thousands of aircraft including about 200 foreign are identified, plotted, and tracked each day and night.

2. Hundreds of satellites and debris from satellite launchings are continually observed. Within a few minutes after the launching of a satellite, the complex computers can tell its course around earth, its high and low points, and to within a few seconds, when it will return to the atmosphere and burn.

3. We have three vast radars screens stretching from Alaska, through Canada to Iceland. These will enable NORAD to tell within two or three minutes whether a U.F.O. originating in the USSR is a bomber, a satellite, or an ICBM. A satellite would be tracked promptly. A plane would be met and observed by American fighter planes. If it were a hostile bomber, it would be engaged in combat. If it succeeded in penetrating our first line of defense, it would be turned over to the Nike defenders. All defense by Nike is coordinated here. It is left to the different operational regions to decide which base would handle which plane or group of hostiles. If NORAD decides an ICBM is on the way, at present all that can be done defensively is to give the area of impact about 15 minutes warning to seek shelter. Offensively, our strategic air forces, our long range missiles, and our Polaris submarines would retaliate, but not before a considerable part of our country would be destroyed.

Thus we need not only a good defense, but a strong and obviously alert nuclear retaliatory capability that will deter and restrain any country with sanity at the helm. I hope there are excellent psychiatrists in all corners of the globe, who can get to these psychotics, before they destroy the universe.

54 State Street

Alcoholism in the male cannot be understood unless it is seen as, and handled as, a total family problem.

Multiple Conjoint Family Groups In The Treatment Of Alcoholism

Kenneth K. Berman, M.D./East Orange*

For three years we have been conducting multiple conjoint family therapy in the treatment of alcoholism. In these groups, individuals with severe drinking disorders predominate. At times both the in-patient husband and the out-patient wife have drinking problems of considerable gravity. This often leads to severe marital disturbances, and consequently, to bringing-up unhappy, neurotic, and at times sociopathic children, As a rule, out of a cluster of five family groups four husbands (in-patients) and perhaps one or two wives (out-patients) have chronic severe drinking problems ranging from medium-severe to greatly-excessive. These groups which meet regularly twice weekly, each time for one and one-half hours, continue in treatment for from 12 to 26 sessions.

Alcoholism is, of course, difficult to treat but it can often be successfully treated by the use and judicious application of the multiple conjoint family therapy approach in married couples. This approach promises a more consistent and permanent reversal of the prevailing and long standing pathological pattern. A group which consists of several family clusters (optimally five couples in one group) most of whom have severe drinking problems leading to chronic and deep marital disharmony offers great advantages. Such a multiple family group tolerates better the anxiety which an individual with drinking problems generates and activates. A family group, in which many deep seated problems of the dependency-independency dilemmas (and among them, alcoholic problems) are an avenue of life for most of the members, male or female, provides real advantages. All the group members, on entering therapy, swiftly learn that they will be treated and that they will be ventilating among individuals suffering from similar problems and that they will soon be fully accepted by the whole group. Later, while in the group process, they realize that should a group member express feelings that he wishes to remain a person with drinking problems (and should he feel inclined to defend it as a desirable way of life) he is vigorously challenged by other group members. They ask what really makes it so desirable to him. He then is confronted with a situation where he is facing those who have a better understanding of the drawbacks of the life of an individual who drinks to excess. They usually break down his rationalizations and intellectualizations stating that this is just what he really wants. This breaking down of one's rationalizations and intellectualizations by a group of his peers is speedily accomplished in a way that no therapist (in the one-to-one relationship in individual therapy) could ever accomplish. The anxiety activated when one's rationalizations and intellectualizations are disturbed causes those involved to commit themselves fully to treatment. The reassurance so frequently offered by members of the group (who have under-

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gone change in orientation) encourages them to continue treatment.

In a group like this, catharsis is greatly accelerated. Group members divulge more and more of their early and significant life experiences. Usually the production of each group member will bring forth similar recollections in others. The impact of the fragmentary or near total recall, and the following discussion by a number of group members leads to a much clearer understanding of the initial attitudes which stubbornly block their adjustment at a much more mature level of development. In this type of family group, the resistances are more easily broken and removed by group discussion. The universalization effected by a recall of so many similar experiences in life activates healthy transferences among the members of the group.

The emotional investment which each group member has in the others provides a constant "reality demand" for efforts to understand their involvement, and to work through to more mature adjustments. All members are greatly sustained by group support as they commit themselves more and more deeply to a healthy (and non-drinking) company and activities. Interpretations made in such a multiple family group (in the presence of the patient's spouse or other family members) can have a great therapeutic impact if done skillfully at appropriate times and in proper situations.[2]

In our groups we constantly encourage the group members to give up completely the drinking "friends", and to keep up new friendships with healthy and more mature people in and outside their community. Wives are frequently much more helpful here than their husbands.

Later, we make it unmistakably clear that we regard group members' alcoholic "acting out" as but one of many symptoms, and that they, in addition, give evidence of passivity, inadequacy, immaturity, and dependency. We stress the very frequent fact that the wives have (in addition to the above) the deep need for nurturance and for mothering their husbands — those husbands who appear to vacillate constantly between the deeply seated dilemma of dependency and independency needs.

We emphasize that it is our goal to bring about a significant reorganization of personality structure which will enable the group members to live their lives as responsible, sober, and happier individuals. As the basic conflicts are better recognized and worked through, we expect our patients to become more mature in every aspect of their lives. Our family group sessions are conducted along dynamically-oriented lines. Each session lasts 90 minutes. The greatly accelerated catharsis, the breaking down of rationalizations and intellectualizations, the multiple structure of transferences, and the group capacity to deal with all kinds of resistances are all of paramount importance in the therapeutic progress and maturation of the group members. Ego strengthening occurs as a result of acceptance and tolerance of other group members, and identification with those who have already undergone change here plays a most significant role in the steady growth of group members. The most helpful facet is the group assistance in the working through process. All group members by their own repeated admissions look forward greatly to the twice weekly sessions and consider them as the most meaningful activity of the week. The fellowship of the group and the "being in the same boat" feeling helps its members to tolerate uncomplimentary comments, sarcastic remarks, and provocative statements, because all of that is being done by those toward whom they have developed positive transference feelings. This kind of verbal play can be compared to the kind of play taking place in the pre-school period. In this period, children develop the most important feeling of belonging. Because it is carried out by persons who have become regarded as friends, this helps to prepare them for more intimate contacts with all kinds of sober peers with diminished anxiety.

Not all who have drinking problems are treated with equal facility. Those who are

strongly disillusioned with their way of life, those who are exceedingly anxious, most-fearful of the loss of spouse, those over-guilty of their unacceptable life's pattern are the ones most likely to succeed. Those with sufficient ego strength are the more fortunate ones. But those who have had previous psychotherapeutic or other treatment, and were disappointed with it, as a rule, do poorly. The resistances and defenses of these patients are so highly rationalized and intellectualized that it is most difficult for them to get, actually, fully involved with the group.

To treat patients with severe drinking disorders more successfully, nothing is more important than the change of certain prevailing attitudes. The existing pessimistic (and often outright rejecting) attitude of many psychiatrists must change, if positive results are to be expected. Nothing is of greater importance in the eventual outcome of treatment than the attitude of the therapist toward the patient and the disorder under treatment. The therapist who dislikes treating patients and their families with a particular disorder (or who believes that there is little or no likelihood of permanent success) will unconsciously communicate this deep seated feeling to the patient and his family, and little if anything will be or can be accomplished. Further, the patient must accept the fact that his is a purely psychological and not a moral or ethical problem.

One of the striking and most intriguing aspects of this study is that the hospitalized husband, nearly always has strong dependency needs which are totally unacceptable to him. The wife, who attends the psychotherapy sessions concurrently with her husand (as an outpatient) frequently exhibits signs of a domineering nature, and concomitantly produces a deep need to nurture, protect, and feed. Activity and passivity, then, are here intermingled and placed in juxtaposition in the same person. When, through psychotherapeutic intervention, these conflicts can be resolved, a most helpful and interesting amelioration of the whole marital climate ensues.

We have found in our clinical and research experience with large numbers of family groups in the last few years that the core conflicts are most crucial and pivotal to the emotional disorders of the two involved partners, and that solving this particular problem leads to a much better and much more mature marital relationship.

With changes in attitude, much can be accomplished in the way of solution or at least some amelioration of the distressing illness we call chronic severe drinking. Prophylaxis here should become a matter of greater public concern. Parental education from the very early formative years could prevent much of the future tragedy caused by drinking. Further research in this so very critical and sensitive an area might vastly contribute to better clarification and understanding of the fact that without multiple conjoint family therapy there are so many readmissions of married patients to the psychiatric (and often medical) service of our hospitals. With the help of this type of therapy, the number of readmissions in this group conspicuously dwindles.

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Veterans Administration Hospital

1968 Annual Meeting

Saturday, Sunday, Monday, Tuesday, Wednesday May 18-22, 1968

Haddon Hall, Atlantic City

Most effective medications have side-effects. Here reported is a topical medication where there were no side-effects and where all patients in the series improved or actually recovered completely.

Topical Neomycin-Dexamethasone Alcohol In Infected Dermatoses

Jack Kindler, M.D./East Orange

The pyodermas of primary and secondary infected dermatoses are refractory to treatment.[1] The underlying dermatitis is frequently aggravated by the bacterial organisms which in turn become more pathologically effective because of further break down of skin resistance. Resident and transient microflora will, under these adverse conditions, take on added significance and may cause worsening of the clinical disease.[2] Control of both the dermatitis and the infection should be accomplished in the minimum length of time to reduce the possibility of systemic bacterial involvement. Neomycin is desirable for this function not only because of its rapidity of action and its versatility but also because it permits saving of other locally used antibiotics for possible systemic use.[3] Gould and Olansky[4] state in reference to the dexamethasone used in this study "the synthetic glucocorticoid adrenocortical hormones (cortisone, hydrocortisone-type steroids) occupy a generally well established and perhaps distinctive place in palliative management of . . . allergic and inflammatory disorders."

I have studied the effect of this dexamethasone cream with the addition of neomycin in a variety of primary and secondary infected dermatoses. After a clinical diagnosis of pyoderma was made, a pre-therapy culture was taken and treatment begun. The patient was instructed to apply the medication several times a day. The neomycin-corticoid formulation* used contained neomycin sulfate 0.5 per cent, dexamethasone alcohol 0.04 per cent in a bland, water washable, odorless, and non staining cream type base. In some instances adjunctive treatment was also given. The patient was seen periodically and results noted. At a point of either cure or significant change, reculture† was performed. Primary or secondary innoculum was identified (where possible) as to organism, hemolysis, coagulase activity, and sensitivity. Sensitivity studies were done for the most part before separation of the mixtures of organisms. These were done using the code letters and concentrations listed in Table 1.

Table 1

Bacitracin	B	2 Units
Chloramphenicol (Chloromycetin)	C	5 MCG
Erythromycin	E	2 MCG
Sulfamethoypyridazine	KY	50 MCG
Sulfadimethoxine	MA	50 MCG
Neomycin	N	5 MCG
Oxacillin	OX	1 MCG
Penicillin G	P	2 Units
Tetracycline	TE	5 MCG

Sixty-three patients were studied and fifty-six reported. Seven were lost to follow-up or were discarded because of technical factors. The fifty-six patients includes 24 females. They ranged in age from 3 to 76 with an average age of 25. No controls were used. Table 2

* Supplied as Hexadrol Cream® with Neomycin by Organon, Inc. West Orange, New Jersey.

† We used Difco blood agar culture media.

shows the number of patients in each diagnostic category.

Table 2. Categories of Dermatoses

Primary Infection or Secondary Infection of Dermatitis	*Number of patients*
Contact Dermatitis	4
Furunculosis	4
Infected Eczema	14
Acne Vulgaris	10
Sycosis Barbae	6
Atopic Dermatitis	8
Nummular Eczema	2
Impetigo	2
Pyoderma	6

Results

The neomycin-dexamethasone cream was found effective in alleviating and controlling pruritis and inflammation associated with various dermatoses. Primary and secondary infections of the skin were also controlled. Of 56 patients treated, 38 improved and 18 recovered completely. None were worse and none remained unchanged. See Table 3. Not

Table 3 Results

Total Cases		*Substantially Cured*	*Considerably Improved*
4	Contact Dermatitis	3	1
4	Furunculosis	1	3
15	Infected eczema	2	12
10	Acne vulgaris	0	10
6	Sycosis barbae	4	2
8	Atopic dermatitis	0	8
2	Nummular eczema	0	2
2	Impetigo	2	0
6	Pyoderma	6	0
		18	38

No patients remained the same and none became worse.

one of these 56 patients was resistant to neomycin. No attempt was made to classify clinical entities according to predominating organisms or relationship to therapy. In many of the patients, the underlying chronic dermatitis remained although somewhat improved because of the lessening of inflammation and infection. Treatment did not have to be discontinued in any case due to a worsening of the condition, contact dermatitis, or lack of patient acceptability. Most patients found the preparation* cosmetically acceptable and "softening" to the skin.

The following brief histories are illustrative:

Case 1: a 35-year-old male with sycosis barbae of four weeks duration cleared in three weeks with hot boric acid compresses four times a day followed by the neomycin-dexamethasone cream.* Pre-therapy Culture showed Staphylococcus aureus, hemolytic — coagulase positive, staphylococcus albus — coagulase negative.

Sensitivity: N,B,C,E,K,Y,MA,OX,P,TE.

Post-therapy Culture: No organisms found.

Case 2: A 31-year-old female with a secondarily infected nummular eczema of many years duration significantly improved in six weeks after applying neomycin-dexamethasone cream* every 4 hours. The eczema remains improved and free of clinical infection. Her pre-therapy culture showed Staphylococcus aureus, hemolytic — coagulase positive, e. coli, strep. fecalis, diphtheroids.

Sensitivity: N,B,C,OX,P,E,KY,MA,TE.

Post-therapy culture: E.Coli, diphtheroids.

Sensitivity: N,B,C,OX,P,E,KY,MA,TE.

Case 3: A 6-year-old girl had atopic dermatitis, secondarily infected, since several months of age. She improved after six weeks of neomycin-dexamethazone cream* four times a day. The chronic atopic dermatitis remains with less erythema and no obvious secondary infection. Her pre-therapy culture showed Staphylococcus aureus, hemolytic — coagulase positive and e. coli, diphtheroids.

Sensitivity: N,B,C,OX,P,E,KY,MA,TE.

Post-therapy culture: E. coli

Sensitivity: N.B. Resistant: C,E,KY,MA,OX,P,TE.

Summary

Neomycin-dexamethasone was found uniformly effective in a variety of primary and secondary skin infections. Of 56 patients treated, 18 completely recovered and 38 improved. The *in vitro* bacteriologic studies supported the clinical improvement of the treated dermatoses. The preparation* was well accepted by the patient and free of side effects. It is a therapy well worthy of inclusion in our armamentarium.

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* Hexadrol Cream with Neomycin, Organon, Inc.

109 South Munn Avenue

One would suppose that the combination of a tranquilizer and a mood-elevator would result in a zero effect, each cancelling the other. However, as shown here, the combination can be very useful in depression.

Treating Anxiety And Depression In High School Students

Robert A. Weinstein, M.D., Gaetano Ruggieri, M.D., and Cora S. Baldos, Ph.D., Newton*

Garber[1] has reminded us that more human suffering has probably resulted from depression than from any single disease. Indeed some two million persons, young and old, in this country have made at least one suicide attempt. In addition, there are millions more of mildly depressed people who never seek help because they fail to realize they are ill.

Since its introduction in 1960,[2] amitriptyline† has become an accepted therapeutic agent for a variety of depressive reactions. At first, its prime usefulness apparently was in psychotic depressions. However, with increased clinical usage,[3] the compound has been reported[4] effective in controlling neurotic reactive depressions[5] associated with the anxiety state.

Many patients with an acute or chronic somatic illness also present symptoms of apprehension, weakness, listlessness, or other complaints which suggest a secondary depression. Thus, the clinician sometimes has difficulty in deciding whether the patient should be treated with stimulants, antidepressants, or tranquilizers. Stimulants such as caffeine and amphetamine derivatives are unsatisfactory in controlling these symptoms. Sedatives and tranquilizers, although effective *per se* for the anxiety state, are not ideal if depression is the major component.[6]

Kline[7] lists the five commonest symptoms of depression as follows:

(1) feeling of sadness

(2) fatigue

(3) loss of interest in social environment

(4) self neglect

(5) insomnia (often of the early morning type, in which the patient goes to sleep without too much trouble but awakens early with marked feelings of depression and often anxiety)

However, some depressive reactions present themselves with only slight resemblance to such characteristic patterns. Some depressed patients complain of nothing more than a disturbance of sleep pattern. Others report of a pain or other symptoms of organic illness, for which no satisfactory somatic explanation can be found despite intensive searches.

Batterman, *et al.*,[8,9] made a useful clinical study of amitriptyline in these depressive reactions. They found good results with minimal side effects. But they suggested that a combination of an antidepressant and a tranquilizer offered the physician a better ap-

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† Manufactured as Elavil® HCl Tablets, Merck, Sharp and Dohme.

proach to the depressed-anxious patient. They concluded that a medication possessing these dual-acting properties would be advantageous.

In 1963, Ingals, *et al.*,[10] reported on the effects of amitriptyline and an antidepressant. For the first time, they used pre- and post-treatment testing to determine the effects of these compounds on the personality patterns of patients. In this procedure, amitriptyline alone was used in a control group of hospitalized patients. They used the Maudley Personality Questionnaire in determining personality and moods. This questionnaire (developed by Isonic) purports to inventory personality variables, introversion, extroversion, and neuroticism. They also used the Hildreth[11] "Feeling Scale," which is intended to reflect the subject's expression of depression or elation with its obvious relevance to mood changes. In addition, they applied the Mill-Hill Vocabulary Test and the Brengleman picture recognition test.

Treated patients showed a significant elevation of mood on the Hildreth scale and some improvement in the depression rating scale. The Ingalls group concluded that amitriptyline was certainly useful in psychoneurotic depressions and probably useful in the manic-depressive psychoses.[10]

As a result of these and other reports, it was decided to evaluate a combination of perphenazine (a tranquilizing agent) and amitriptyline hydrochloride (an antidepressant)** in the treatment of 46 high school outpatients who had a mixture of anxiety or agitation plus symptoms of depression. The students' ages ranged between 12 and 19. Half were to be treated in the Mental Health Center and half in the office.

The 26 patients treated in the office were followed to completion; but three of the 23 patients treated in the Mental Health Center dropped out of the project. Of these, 21 were males (Chart I). The symptoms were no more severe in one sex or age group over the other. However, almost half of our cases were among the 17 to 19 age group.

CHART I

Anxious—Depressed Secondary School Students Evaluated In Study

Age	Male	Female
12	3	0
13	3	1
14	3	2
15	5	3
16	3	1
17	2	4
18	0	6
19	2	8
Total	21	25

Method Of Study

A modified double blind crossover study was made. None of the investigators was aware of the compounds used; only the technician who packaged the materials (according to a code) knew which product was A and which was B.

The 26 patients studied in the first group were given a psychological work-up, including the D.A.P. and Mooney Problem Check List (High School Form). They were then given Product B, three times a day for six weeks. We discovered later that Product B was amitriptyline. Following the completion of this period, similar testing was done to note any change in symptoms. Each of the patients then had a rest period of one week, during which Product A (amitriptyline hydrochloride-perphenazine) was used. Upon completion of the study, they were again tested. The reaction changes in the five symptoms outlined in Chart II were the criteria established for the study. The five symptoms included: anxiety, depression, lack of alertness (or cooperativeness) during the examination, inability to deal with homework, and lack of improvement in sleeping patterns. The symptoms were graded 1+, 2+, 3+, and 4+. One-plus was 25 per cent or mild; 50 per cent was 2+ or moderate; 3+ was 75 per cent or severe; and 4+ was 100 per cent or very severe. Response to treatment was noted in similar gradings. Some of

** Etrafon® A Tablets (4-10), Brand of Perphenazine-Amitriptyline Hydrochloride, Schering Corporation.

CHART II

Anxious—Depressed Adolescents Treated By Crossover Technic (Double-Blind)
Amitriptyline (1st)—Perphenazine-Amitriptyline (2nd)

	Prior to Treatment B	After Treatment B	Subsequent Treatment Product A
Anxiety	18 (++++) 6 (+++) 2 (++) 0 (+)	15 (++++) 5 (+++) 5 (++) 1 (+)	2 (++++) 2 (+++) 18 (++) 4 (+)
Depression	10 (++++) 13 (+++) 3 (++) 0 (+)	6 (++++) 9 (+++) 10 (++) 1 (+)	0 (++++) 2 (+++) 12 (++) 11 (+)
Lack of Alertness-Cooperativeness during Examination	0 (++++) 12 (+++) 9 (++) 5 (+)	1 (++++) 10 (+++) 6 (++) 9 (+)	1 (++++) 0 (+++) 3 (++) 22 (+)
Lack of Ability to Deal with Homework	2 (++++) 5 (+++) 17 (++) 2 (+)	0 (++++) 2 (+++) 19 (++) 5 (+)	1 (++++) 1 (+++) 5 (++) 19 (+)
Lack o fImprovement in Sleeping Patterns	1 (++++) 6 (+++) 14 (++) 5 (+)	0 (++++) 4 (+++) 10 (++) 12 (+)	0 (++++) 0 (+++) 4 (++) 22 (+)

Clinical observation of psychologist expressed in + indicating the presence of symptoms or positive findings.

+ = 25% = mild ++ = 50% = moderate +++ = 75% = severe ++++ = 100% = very severe

the patients, of course, demonstrated more than one symptom and of varying grades.

Of these patients, eighteen were graded as 4+ anxiety, ten as 4+ depression, two as 4+ in inability to deal with homework, and one as 4+ in lacking improvement in sleeping patterns. After treatment for six weeks with the amitriptyline (B) in the eighteen patients with anxiety, fifteen remained in the 4+, or very severe state; six of the ten individuals with depression remained in the 4+ state. Ability to deal with homework was improved in two students, we also noted improvement in sleeping patterns in the remaining patient. However, one youngster became more severely involved with lack of alertness and cooperativeness during the examination in the second phase, whereas previously there had been none. The results were considered as a 16 per cent improvement in the severe anxiety phase and a 40 per cent improvement in the severe depressive phase.

After a rest period of one week, a crossover study was made with Product A (4 milligrams of perphenazine and 10 milligrams of amitriptyline), also on a six-week basis, three times a day. Only two patients remained in the 4+ anxiety, none in the 4+ depression, one in alertness, and one in the lack of ability to deal with homework. All subjects showed improvement in sleeping patterns. This result was an 88 per cent improvement over that which was accomplished with Product B and a 100 per cent improvement over Product B in the depression phase. This confirmed our thesis that combining an antidepressive with a tranquilizing agent would be efficacious and would be an improvement over an antidepressive agent alone, in severely depressed and anxious teenagers and adults.

Side effects encountered with the amitriptyline alone, included dryness of the mouth, drowsiness, dizziness, and tendency to fall asleep during class work. There were also several instances of blurred vision. These side reactions improved perceptively when the medication was discontinued. There was only a five per cent complaint of drowsiness with the combination product. However, omitting the afternoon dose easily corrected the side reaction.

CHART III

Anxious—Depressed Adolescents Treated By Crossover Technic (Double-Blind)
Perphenazine-Amitriptyline (1st)—Amitriptyline (2nd)

	Prior to Treatment A	After Treatment A	Subsequent Treatment Product B
Anxiety	14 (++++) 4 (+++) 2 (++) 0 (+)	1 (++++) 6 (+++) 2 (++) 1 (+)	8 (++++) 7 (+++) 2 (++) 3 (+)
Depression	5 (++++) 10 (+++) 5 (++) 0 (+)	1 (++++) 4 (+++) 4 (++) 11 (+)	2 (++++) 10 (+++) 4 (++) 4 (+)
Lack of Alertness-Cooperativeness during Examination	0 (++++) 7 (+++) 9 (++) 4 (+)	0 (++++) 0 (+++) 2 (++) 18 (+)	0 (++++) 4 (+++) 10 (++) 6 (+)
Lack of Ability to Deal with Homework	2 (++++) 11 (+++) 7 (++) 0 (+)	0 (++++) 1 (+++) 7 (++) 13 (+)	0 (++++) 7 (+++) 9 (++) 4 (+)
Lack of Improvement in Sleeping Patterns	1 (++++) 8 (+++) 9 (++) 2 (+)	0 (++++) 1 (+++) 2 (++) 17 (+)	0 (++++) 2 (+++) 14 (++) 4 (+)

Clinical observation of psychologist expressed in + indicating the presence of symptoms or positive findings.

+ = 25% = mild ++ = 50% = moderate +++ = 75% = severe ++++ = 100% = very severe

The second group of twenty patients was treated in reverse to the first portion of the study. They began with perphenazine-amitriptyline and then were crossed over to amitriptyline. Fourteen of these patients had 4+ anxiety, and five had a 4+ depression. Two individuals demonstrated inability to do homework. There was one 4+ with failure to improve sleeping patterns. Following the six-week treatment with perphenazine-amitriptyline, only one patient remained with a 4+ anxiety and one with a 4+ depression. No patients demonstrated inability to deal with homework or failure to improve sleeping patterns. This indicated a marked improvement over the number of patients who were severely anxious (80 per cent) or severely depressed (80 per cent). There was a 100 per cent improvement in ability to deal with homework and a 100 per cent improvement in sleeping patterns.

At the end of a one-week resting period, these same patients were crossed over to amitriptyline. Eight patients showed an increase to a 4+ anxiety, and one individual became depressed. The other patients remained the same. Once again, the results confirmed our premise that this age group responds better to a combination of antidepressant and tranquilizer than to an antidepressant alone.

Early in the study, five of our patients felt so much better on Product A (perphenazine-amitriptyline) that they refused to continue with Product B and had to be dropped from the experiment.

Drowsiness on the afternoon dose was more marked with the single preparation (18 per cent) than with the combination product (5 per cent).

Comment

Although there was considerably more drowsiness with amitriptyline alone, some afternoon drowsiness in teenagers was also present with amitriptyline and perphenazine. To prevent this, we suggest halving this dosage, especially in teenagers attending school. More specifically, we recommend that for better results in emotional instability, the dose for younger teenagers be reduced, and

for older teenagers the ratio be four milligrams of perphenazine to ten milligrams of amitriptyline, in treating these cases where there is mixed anxiety and depression, rather than using an antidepressant alone.

Conclusions And Summary

(1) More human suffering has resulted from depression than from any other single disease. Two million persons in this country have made at least one suicide attempt while depressed. There are millions of mildly depressed persons who never seek help because they fail to realize that they are ill.

(2) Amitriptyline is a well accepted and well proved therapeutic agent for depressive reactions.

(3) Depressive reactions accompanied by anxiety are best treated with an antidepressant and a tranquilizer in combination rather than with a single antidepressant agent.

(4) In this study, a modified double blind crossover in 46 patients was made. One preparation was amitriptyline, which is an antidepressant. The other was perphenazine combined with amitriptyline,** which had both a tranquilizing and an antidepressant effect. Prior to initiation of study, patients were evaluated according to the "draw-a-picture," and Mooney Problem Tests.

(5) Twenty-six patients were treated with Product B, which was amitriptyline. They were then crossed over to Product A, which was perphenazine-amitriptyline combination. Twenty patients were treated similarly but in reverse by using perphenazine and amitriptyline for six weeks, a one-week rest period, and then crossed over to amitriptyline. Psychologic testing was repeated midway and at the completion of the study.

(6) Careful search of the literature failed to reveal the use of any such method in previous studies on teenagers.

(7) The study revealed that an 80 to 90 per cent improvement in anxiety and depressive states can be achieved when a combination of the drugs, such as perphenazine-amitriptyline,** is used rather than an antidepressant alone.

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Preventing tuberculosis is not a theory; it can be done, and it works!

Child Centered Preventive Treatment For Tuberculosis*

William J. Dougherty, M.D./Trenton

The invasion of the human body by tuberculosis organisms results first in infection. The presence of the infection in the body will become apparent if a skin test for tuberculosis is given. A swelling (tuberculin reaction) will develop at the point at which the test is made. This reaction does not indicate the degree or severity of infection suffered by the individual. This may be determined by x-ray and other studies.

If the body is able to defend against the destructive activity of tuberculosis organisms, the infected state persists and clinical tuberculosis is not apparent. However, if the bodily defenses fail and the tuberculosis organisms cause destruction of tissue, clinical tuberculosis exists. A person so involved is said to have tuberculosis.

Prospective studies have been conducted on young adult males in their teens and early 20's who (on selective service examination and initial examinations as naval recruits) were found to be free of clinical tuberculosis or a recent history of clinical tuberculosis. The men were tuberculin-tested and x-rayed upon entry into recruit training and followed through their enlistment with repeated skin testing and x-ray examination. These studies have revealed information related to the development of clinical tuberculosis among tuberculin reactive persons, that is of significance to tuberculosis control among the young in New Jersey. The results are as follows:

1. The rate of new active tuberculosis in naval recruits having a tuberculin (Purified Protein Derivative Standard, PPDS) reaction in excess of 11 millimeters of induration was demonstrated to be 357/100,000 tested during their enlistment period. This clearly specifies the risk of the development of active tuberculosis in tuberculin reactive young male adults.

2. The rate of new active tuberculosis in naval recruits having a tuberculin (Purified Protein Derivative Standard, PPDS) reaction between 6 and 11 millimeters of induration varied between 242/100,000 to 107/100,000 tested in those recruits whose tuberculin reaction (Purified Protein Derivative Standard, PPDS) exceeded or equalled the reaction to Purified Protein Derivative Battey (PPDB).[1]

3. The rate of new active tuberculosis in recruits whose PPDB reaction exceeded the PPDS reaction varied from 5/100,000 to 19/100,000 tested. These findings clearly indicate the need for differential skin testing of all persons having tuberculin reactions under 10 millimeters of induration.[1]

Control of tuberculosis can be achieved when the tuberculosis organisms within the tissues of man can be so confined by bodily defenses and environmental factors that their progeny cannot be exploded into the air to be inhaled by a non-infected person. Isolation, improved nutrition, rest, improved economic circumstances, more ample living space, antibiotics, and chemotherapy have all contributed to control by progressively diminishing the amount of clinical tuberculosis and the repetitive aerosol explosions of organism into

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the environment. A new major attack upon the organism and this clinical disease is now available: *Preventive Therapy.*

Public Health Service studies of contacts and others exposed to the risk of tuberculosis have shown that Isoniazid taken daily for one year has decreased the frequency of tuberculosis by 75 per cent during the year of medication and by at least 50 per cent thereafter. In view of these findings, it is now possible to identify persons infected with tuberculosis among whom the risk of developing active tuberculosis is high and, by systematically applying the drug Isoniazid as preventive therapy, to reduce materially the risk of active tuberculosis.

The Public Health Service and its Tuberculosis Control Advisory Committee have recommended that a program to identify tuberculosis infection by skin test and then to treat tuberculosis infection be incorporated into the nationwide tuberculosis control program. They have recommended further that priority be given to a child centered program of preventive therapy. The incidence of active tuberculosis among children and young adults in New Jersey is apparent in the following data from 1966.

Age Group	*Rate per 100,000*
Under 5	15.9
5 - 14	4.9
15 - 24	15.8
25 - 44	29.5
45 - 64	38.6
65 and Over	42.9

The discovery of children, adolescents, and young adults infected with tuberculosis and their subsequent preventive treatment with Isoniazid can be used to reduce substantially the incidence of active tuberculosis in New Jersey.

A part of the mechanism for this action already exists in the public and parochial school tuberculosis screening programs. Amplification of these programs by the introduction of systematic preventive therapy will greatly enhance tuberculosis control in this state. New Jersey has tuberculin-tested, annually, almost 500,000 public and parochial school students in grades 1, 5, 9, and 12 with the discovery of 12,000 to 13,000 reactors among whom 20 to 25 cases of active tuberculosis have been revealed. It is appropriate to recommend that all of these reactors be immediately involved in systematic preventive therapy. This action will aid in reducing future incidence of clinical tuberculosis in children, adolescents and young adults.

To implement a broadly based systematic preventive treatment program, it will be necessary to modify to some degree the existing school tuberculosis screening programs, and to amplify physician and health department activity. It is proposed that:

1. Tuberculin skin testing should be the major tool for prevention of tuberculosis.

2. Public, parochial, and other private schools should tuberculin test all students in grades 1, 5, 9, and 12.

3. Medical examination of tuberculin reactors should be accomplished by private physicians or health departments in the following way:

a. Chest x-ray examination of all students having tuberculin reactions by any intradermal test, (Mantoux PPD, Tine, Heaf), showing induration of 10 or more millimeters in diameter.

b. Retest students having tuberculin reactions less than 10 millimeters by any intradermal test (Mantoux PPD 5-9 millimeters, Tine 2-9 millimeters, Heaf grade 1) using the differential intradermal antigens Purified Protein Derivative Standard PPDS and Purified Protein Derivative Battey PPDB. Both antigens should be administered at the same time so that comparability can be established. Purified Protein Derivative Standard PPDS and Purified Protein Derivative Battey PPDB will be made available by the New Jersey State Department of Health.

c. All students having reactions to Purified Protein Derivative Standard PPDS in excess or equal to Purified Protein Derivative Battey PPDB are to receive a chest x-ray examination.

4. All tuberculin reactors are to be reported to the State Department of Health with data obtained on differential testing with Purified Protein Derivative Standard PPDS and Purified Protein Derivative Battey PPDB and the results of chest x-ray examinations.

5. Preventive treatment consisting of daily administration of Isoniazid, 5.0 milligrams per Kilo of body weight, for 12 months, be administered under medical guidance with parental consent to all students having tuberculin reaction in excess of 10 millimeters of induration and to all with reactions between 5 and 10 millimeters of induration whose Purified Protein Derivative Standard PPDS reaction exceeds or equals the Purified Protein Derivative Battey PPDB reaction.

6. Communities having large unanticipated case loads of reactors should initiate preventive therapy on a priority basis in the following order: grade 12, 1, 9, and 5. This will be consistent with the National Communicable Disease Center Program to provide therapy to "School enterers and leavers."[2]

7. Health departments should maintain follow-up on all reactors on preventive therapy to assure that adequate use of medication is achieved. Follow-up will include issuance of drugs for preventive therapy at intervals not exceeding every 2 months and chest x-ray examination at the 8th and 12th month of follow-up, if not indicated sooner.

8. A register of students on preventive therapy ought to be developed by the local health department to assure that complete preventive treatment is achieved.

9. Health departments should determine all family associates of first grade reactors and assure that they are examined to detect source cases of active tuberculosis.

10. A vigorous campaign of community organization and education is needed to foster the preventive therapy program.

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The Federal Food and Drug Administration announces a new procedure for calling attention to urgent communications. On the front of the mailing envelope will appear a new design in space 3 × 2¼ inches as follows:

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Office nurses, secretaries, and receptionists should be alerted to this color code so that they may route these announcements to their employer for urgent personal attention. What happens then is the boss's responsibility and a very grave one indeed.

The facts about our State's resources here should be known by all New Jersey physicians.

New Jersey's Resources For The Mentally Retarded

Maurice Kott, Ph.D./Trenton*

During the past decade, our State has dramatically increased the number and types of programs available to the retarded. The overall program is now so large, diverse and interrelated, and involves so many independent institutions and agencies that it has become necessary to pull together the various segments of the total program to ensure its continued forward development in a systematic fashion. To this end, Governor Hughes appointed an Interdepartmental Committee on Lifetime Disability and an Advisory Council with broad representation. The Committee has developed a comprehensive plan to combat mental retardation in the state by establishing a Working Party on Mental Retardation. The Working Party has compiled a roster of existing services for retarded individuals and has formulated a list of additional services which might be considered ideal. A project staff was developed by the Working Party to gather information and organize meetings with professional and voluntary organizations. At present a new *Directory* published by the New Jersey Association of Retarded Children is ready for distribution. This provides a list of all available resources in the State.

Public programs of New Jersey in the field of mental retardation are conducted by six departments, reflecting the need for a multidisciplinary approach. Under the Maternal and Child Health Program and the Crippled Children's Program, the Department of Health underwrites the expenses of diagnostic evaluation and follow-up for the mentally retarded as well as physically handicapped children with particular emphasis on the pre-school child. Evaluation is provided by a professional team co-ordinated by a medical director and including a pediatrician, psychiatrist, psychologist, medical social worker, and public health nurse. Consultant services by board-certified specialists are also available in various fields including orthopedics, neurosurgery, plastic surgery, and ophthalmology. Four diagnostic and evaluation centers are conducted under the auspices of the Department of Health.

The Department of Education provides aid to local school districts. These are required to identify and provide appropriate educational programs for mentally retarded pupils. As a result of the Department's efforts, there has been a tremendous increase in the number of classes for educable and trainable children in recent years. The total is now 18,000 children in New Jersey. Local school boards are required to obtain the services of State-approved psychologists and clinics to evaluate all mental retardation suspects referred to them and to provide suitable facilities and programs of education, either by establishing special classes in a district or by sending pupils to a special class in the public school of another district or by providing individual instruction or training at home.

The Department of Labor and Industry is concerned in the problem of mental retarda-

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* Dr. Kott directs the Mental Retardation Division of our State Department of Institutions and Agencies. This talk was given at the Middlesex General Hospital in New Brunswick on April 5, 1967 as part of a symposium on the retarded child. Held under the chairmanship of Dr. Sylvan Moolten, this colloquium, supported by Merck, Sharp and Dohme, was under the auspices of the Academy of Medicine of New Jersey and the Central Jersey Pediatric Society.

tion chiefly through the New Jersey Rehabilitation Commission. Twenty district offices have been designated for this purpose. The program of the Commission is centered about mentally retarded individuals over the age of 16, providing direct services in the form of physical rehabilitation where needed, special training, co-ordination with sheltered workshops and necessary medical and surgical treatment to enable the retardate to function in some useful capacity.

The Department of Institutions and Agencies provides day care centers for the non-educable and non-trainable severely retarded children who are excluded from public school programs. These children are somewhat helped by their group experience. At the same time, the mother is relieved of the necessity of minute-to-minute care and is thus enabled to recuperate her physical, mental, and emotional resources.

A referral system has been organized in four major regions through which the necessary information can be acquired on the best way of handling a problem in mental retardation and the available facilities. This includes referral for proper workup and for continuity of evaluation and care subsequently. Through this means the state takes each case "by the hand" to ensure maximal utilization of facilities now available for their benefit. For the area comprising Hudson, Bergen, Essex, Passaic and Union Counties (Region I) the telephone number of the center is 744-7797. For Warren, Sussex, Morris, Somerset and Hunterdon Counties (Region II) the telephone is 852-1214. For Middlesex, Monmouth, Mercer, Burlington and Ocean Counties (Region III) the telephone number is 292-3720. For Camden, Atlantic, Cape May, Gloucester, Salem and Cumberland Counties (Regional IV) the telephone is Locust 4-5070. Other resources in New Jersey include essential services by the Welfare Department for neglected and dependent mentally retarded children to protect them against secondary disability. This includes financial assistance, homemaker services, foster care placement, guardianship, and protective services. Through assistance to the family, the retardate is often enabled to live at home and thus gains the advantage of living with his own mother and perhaps achieves a better intellectual growth thereby, than if living among strangers.

Numerous community programs are also available in New Jersey. Most of the community programs are either operated by or affiliated with county components of the New Jersey Association for Retarded Children. This citizens' organization has spurred many of the gains in our State and has pioneered in many forms of services including the development of day care centers.

In making provision for the mentally retarded child it is important to establish his classification particularly in respect to degree of retardation rather than type. This evaluation includes his adaptability to his environment and whether he is either educable and trainable, merely trainable, or neither trainable nor educable.

In the classification of the mentally retarded child one is best advised to use a tri-dimensional formula based on etiology, adaptive level, and function. According to this, a retardate is classified first on the basis of medical diagnosis (mongolism, encephalopathy of unknown cause, or functional retardation without known cause). The next element is the adaptive level of the retardate as determined by the actual IQ compared with the potential IQ, if the child were properly managed. The scale of adaptive behavior is determined by simple test procedures such as ability to tie shoelaces. The third element is the degree of functional development.

The duty to inform the parents that a child is mentally retarded is often difficult and painful. This is ameliorated to some extent by the fact that in most cases the parents raise the question first, generally on the basis of comparison with the child's siblings. Most parents are very understanding. In telling a parent that the child is mentally retarded, the physician should be honest from the very

beginning, or at least admit his inability to be certain without additional help. When a physician lacks sufficient information he should refer the child to a "Development and Evaluation Clinic" (this phrase is far preferable to "Mental Retardation Clinic"). Such a clinic should be manned by experienced clinicians, not house officers. To attempt to shield parents from the truth about a retarded child or allay their fears by telling them that the child will outgrow it may incur deep resentment subsequently, when the true nature of the situation unfolds itself. On the other hand to tell a parent brusquely that the child is retarded and should be "put away" as incurable may arouse even more resentment. In general the physician should emphasize some type of dynamic formulation about the child, indicating perhaps that the child is slow and may never be as bright as his brothers and sisters; but the physician and the family can work together to help him achieve a fair measure of adaptation. The doctor should adopt a positive attitude, yet not mislead the family with false hopes.

A physician should also recognize the nature of his own attitude toward the problem and toward the family. If he is able to recognize in himself an attitude of hostility, he should dissociate himself from the case entirely and place it in the hands of a physician with a greater degree of sympathy. Such a physician should be sufficiently understanding to permit the mother an opportunity to talk about her problem and about her unhappiness. He can provide much support through non-verbal communication and suggest an affirmative attitude as much by this means as by what he actually says.

Special problems exist in the case of the mildly retarded adolescent. One finds that he may be *in* the community but not *of* it. Often such a person is at a social disadvantage because of his reading disability yet efficient in other areas. Many of such adolescents are dropouts and many join neighborhood gangs. Their best hope lies in community programs from which many of them benefit tremendously. Much effort is needed in this direction to provide the right type of social organization. Many retarded children are aggressive and difficult while in school, because of their mental difficulty, but become much more tractable when they leave school. Their difficulties have increased in recent years in measure with the steady rise in levels of educational standards. Thus a child who a century ago would have made a good farmer or carpenter may now find himself seriously disadvantaged in comparison with the more intellectually gifted students.

Language difficulties constitute a problem in mental retardation when concerned chiefly with vocabulary. In certain homes conversations are limited to a very small vocabulary of 100 to 150 words. Books and newspapers are lacking and the only actual contact the child has with an enlarged vocabulary may be through television. The narrowness of vocabulary may prove a serious disadvantage in the child's total intellectual development.

The federal government has recently recognized its responsibility for health services to members of the Armed Forces even to the extent of providing services for mentally retarded dependents. This has many important implications for the future. If needed facilities are not available close by they can be "purchased" from non-governmental sources.

One of the great needs in this field at present is increased manpower. The number of physicians cannot be multiplied beyond a certain number. Therefore a large increase in paramedical personnel should be made available.

Family planning is also part of the program but should not be considered necessarily restricted to the problem of mental retardation. It should constitute part of all good obstetrical care. Since 1958, when Dr. Hellman began the struggle that led to the lifting of the ban on contraceptive services in municipal hospitals, New York City has established the most extensive program of clinical services in family planning of any community in the country.

Whether a mentally retarded child should be

sterilized is a matter of deep concern to society and to the family. However, it should be discussed with the family and left to their discretion. It becomes a matter of importance in girls in whom it may be particularly desirable. Again, this is matter of judgment.

The physician should be cautious in the role of a genetic counselor in the prevention of mental retardation because of the rarity of inherited causes. Among the few that are known are tuberous sclerosis and translocation mongolism. If it is established that such conditions exist in the background, the physician is under obligation to impart the information to the family. Otherwise, he should express himself most cautiously in this connection.

135 West Hanover Street

Immunization Booklet For Your Patients

A brief story of how the human body resists infection and an outline of the immunizations currently available are provided in *Immunization For All,* a new Public Affairs Pamphlet by Jules Saltman. It is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, New York 10016.

The human body has a number of defenses against disease. "An unbroken skin is one," Mr. Saltman explains. "White blood cells that can engulf invaders are another. A third are the harmless bacteria and viruses . . . that interfere with harmful ones. . . . But all this *natural resistance* may be of no avail when it has been weakened by illness or when invading germs are too virulent for it." It is then that *specific immunity* must take over — sometimes from the disease itself, against which the body then builds up antibodies that protect against a later onslaught of the same disease; or, more safely, immunity can be achieved from a vaccine.

Mr. Saltman gives major attention to seven of the infectious diseases that can now be prevented by immunization: smallpox, tetanus, poliomyelitis, measles, influenza, whooping cough, and diptheria. He reports on protection against typhoid, tuberculosis, and mumps, and German measles — and on the search for other vaccines, particularly against respiratory diseases and hepatitis. A helpful chart on immunizations tells when to begin, the dosage given and the booster schedules.

Your patient is reminded that additional immunizations are necessary for foreign travel. "Yellow fever and cholera," Saltman writes, "disappeared from the United States many years ago, smallpox more recently. But in some areas of the world these diseases can cause severe epidemics if introduced elsewhere." Jet travel increases the danger, for it is now possible for someone without symptoms to arrive in a country "while incubating a disease contracted in another part of the world."

To protect ourselves and others, the immunizations recommended for various areas of the world are essential. For your traveling patient, Saltman covers smallpox, yellow fever, typhus, plague, cholera, and malaria. He concludes with information about where to get immunizations and a plea for everyone to keep good, up-to-date records of his immunizations.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

November 19, 1967

A regular meeting of the Board of Trustees was held on November 19, 1967, at the Executive Offices. For your further information, detailed minutes are on file with the Secretary of your county society. A summary of the significant actions follows:

Fees For Physicians' Services Under CHAMPUS . . . Approved the action of the Office of the Surgeon General in converting payments on the basis of usual, customary, and reasonable fees for services rendered by New Jersey physicians under CHAMPUS (Civilian Health And Medical Program of the Unified Services) and to discontinue such payments on the current basis of Schedules of Maximum Allowances.

New Jersey State Safety Council . . . Agreed to increase the Society's commitment to the New Jersey State Safety Council to $75 each year for the next three years (1968-1970).

American Mutual Liability Insurance Company . . . Directed that MSNJ extend its appreciation to Mr. Joseph A. Britton for his services (General Manager of American Mutual Liability Insurance Company) to this Society over the years. (Mr. Britton left his position on November 24th).

AMA Community Health Week . . . Directed that the resolution from the Essex County Medical Society, urging the AMA to change Community Health Week to a date in March, April, or May, be forwarded to the AMA Board of Trustees, pointing out that the Essex County Medical Society is the largest component society of MSNJ, and suggesting that consideration be given to this change.

AMA Media Releases . . . Directed that the following resolution from the Essex County Medical Society, together with supporting data, be forwarded to the AMA Trustees:

That (a) the AMA in its future releases to public media adhere more closely to policies formed in its House of Delegates, and (b) the AMA publicity department in the future be reminded to be more aware of the possibility of offending the professions and the friends of medicine in their statements to the public.

AMA Meeting on Drug Addiction . . . Authorized the attendance, with expenses paid, of the Chairman of the Special Committee on Drug Addiction (Henry A. Davidson, M.D.) at the AMA meeting on this subject to be held in Chicago, March 15 and 16.

Health Facilities Planning Council . . . Agreed to commit the Society to a $5,000 contribution to the Health Facilities Planning Council for the fiscal year 1968-69, with the understanding that the Society's support of the council is contingent upon the organization's remaining a voluntary association, with its findings and recommendations continuing as advisory and not controlling.

Your World Of Medical Knowledge

The Academy of Medicine's services to you do not stop at its library in Bloomfield. The Academy is a doorway to our country's national medical library system. Write to the Librarian at the Academy, 307 Belleville Avenue, Bloomfield, New Jersey 07003, or call her at (201) 748-3430. Through this call, you will be able to borrow books and journals from all parts of the country.

Of course, the lending library may want to impose some restrictions on the loan. If so, you will be made aware of them. Please comply. Be sure to note the date the item must be returned and do not retain it beyond this point unless a renewal is effected. Use this privilege to the fullest, and the whole world of medical information will open for you.

Recent Library Acquisitions—Fall 1967

Academy of Medicine of New Jersey

Allergy and Immunology (Lewis Brown Collection)

Leigh, D. Bronchial asthma; a genetic and psychiatric study. Oxford, Pergamon, 1967.

Maimonides, Moses. Treatise on asthma. Philadelphia, Lippincott, 1963.

Sheldon, J. M., Lovell, R. G., and Mathews, K. P. Manual of clinical allergy. Philadelphia, Saunders, 1967. 2nd ed.

Anatomy and Physiology

Anthony, C. P. Basic concepts in anatomy and physiology. St. Louis, Mosby, 1966.

Dean, W. B. Basic concepts of anatomy and physiology. Philadelphia, Lippincott, 1966.

Biochemistry

Bulock, D. Biosynthesis and microbial development. New York. Wiley, 1967. (E. R. Squibb Lectures on chemistry of microbial products)

Grisebach, H. Biosynthetic patterns in microorganisms and higher plants. New York, Wiley, 1967. (E. R. Squibb Lectures on chemistry of microbial products)

Geriatrics and Chronic Diseases

Reynolds, F. W., and Barsam, P. C. Services for the chronically ill and aged. New York, Macmillan, 1967.

Gynecology and Obstetrics

Klemer, R. H., ed. Counseling in marital and sexual problems. Baltimore, Williams and Wilkins, 1965.

Krans, F. T. Gynecologic pathology. St. Louis, Mosby, 1967.

Swolin, K. Beiträge zur operativen Behandlung der weiblichen Sterilität. Göteborg, Elanders, 1967. (Thesis-Göteborg)

Hospitals

Cohen, A. Be patient; your life is in their hands. London, Iliffe Books, 1967.

Hundenburg, R. Planning the community hospital. New York, McGraw-Hill, 1967.

Paetznick, M. Staffing a hospital nursing service. Geneva, World Health Organization, 1966.

General Medicine

Burdette, W. J. Carcinoma of the alimentary tract. University of Utah Press, 1965.

Murine Leukemia. Bethesda, Maryland National Cancer Inst., 1966. (Nat. Cancer Inst. Monog. 22)

Dickens, M. L. Fluid and electrolyte balance. Philadelphia, Davis, 1967.

Dutcher, E. Water and electrolytes. New York, Macmillan, 1967.

Master, A. Cardac emergencies and heart failure. Philadelphia, Lea and Febiger, 1952.

Nat. Acad. of Sciences-National Research Council. Hyperbaric medicine. Washington, D.C., Nat. Acad. Sc., 1966.

Robertson, H. F. Clinical diagnosary. Philadelphia, Hercules, 1964.

Stern, N. S. Rare diseases. Springfield, Illinois, Thomas, 1966.

Viruses of Laboratory Rodents. Bethesda, Maryland, Nat. Cancer Inst., 1966. (Nat. Cancer Inst. Monog. 20)

Taran, L. M. Collected works on rheumatic fever. Flushing, New York, Internat. Prof. Publ., 1967.

Neurology and Psychiatry

Berne, E. Principles of group treatment. New York, Oxford, 1966.

Freedman, A. M., ed. Comprehensive textbook of psychiatry. Baltimore, Williams & Wilkins, 1967.

Mezer, R. R. Dynamic psychiatry. New York, Springer, 1967.

Milt, H. Handbook on alcoholism. Fair Haven, New Jersey, Scientific Aids, 1967.

National Clearinghouse for Mental Health Information. Bibliography on religion and mental health, 1960-1964. Washington, D.C., G.P.O., 1967. (Pub. Health Serv. Publn. 1599)

Ontario. Alcoholism Foundation. How the Alcoholics Anonymous program works. Ontario, Canada, Ontario Province, 1953.

President's Commission on Law Enforcement and Administration of Justice. Task Force on Narcotics and Drug Abuse. Washington, D.C., G.P.O. 1967.

Seaver, J. Cerebral palsy — more hope than ever. New York, Public Affairs Com., Inc., 1967. (Public Affairs Pamph. No. 401)

Shapiro, D. Neurotic styles. New York, Basic Books, 1965. (Austen Riggs Monog. Ser. No. 5)

Toole, J. F. and Patel, A. N. Cerebrovascular disorders. New York, Blakiston-McGraw-Hill, 1967.

U.S. National Institute of Mental Health. The community mental health center. Bethesda, Maryland, Nat. Inst. of Ment. Health, 1967. (Publ. Health Serv. Pubn. No. 1447)

Ophthalmology

Davanger, M. Intraocular pressure. Bergen, Universitetsforlaget, 1965. (Thesis-Univ. Bergen)

Duke-Elder, S. System of ophthalmology. Vol. 1. The eye in evolution. St. Louis, Mosby, 1958.

Duke-Elder, S. System of ophthalmology. Vol. 2. Anatomy of the visual system. St. Louis, Mosby, 1961.

Duke-Elder, S. System of ophthalmology. Vol. 8. Diseases of the outer eye, conjunctiva, cornea and sclera. St. Louis, Mosby, 1965.

National Society for the Prevention of Blindness. Blindness and vision problems. New York, Nat. Soc. Prev. Blindness, 1967. (NSPB Fact Book)

Orthopedics

Burgess, E. M., Traub, J. E., and Wilson, A. B., Jr. Immediate postsurgical prosthetics in lower extremity amputees. Washington, D.C., Veterans Admin., 1967.

Pediatrics

Fomon, S. J. Infant nutrition. Philadelphia, Saunders, 1967.

Reference Books

Conference of Governmental Industrial Hygienists. Threshold Limit Values. Am. Conf. Indust. Hyg., 1966.

Ash, L. Interlibrary request and loan transactions among medical libraries of the greater New York area, by L. Ash and V. R. Bruette. New York, 1966.

Educational Council for Foreign Medical Graduates. Handbook for foreign graduates. Philadelphia, The Council, 1967.

Herner and Co., Washington, D.C. Research in smoking and health, 1967. U.S. Clearinghouse for Smoking and Health, 1967. (Public Health Serv. Publn. 1665)

Medical electronic laboratory equipment. New York, Pergamon, 1967-68. (Pergamon electronics data)

National League for Nursing. Approved Schools of Nursing-RN. New York, Nat. League for Nursing, 1967. 25th ed.

Schmidt, J. E. Reversicon; a medical word finder. Springfield, Illinois, Thomas, 1958.

Smith, G. L. Medical terminology. New York, Wiley, 1967. 2nd ed.

Steen, E. B. Dictionary of abbreviations in medicine and related sciences. Philadelphia, Davis, 1967.

U.S. Bureau of the Census. Pocket data book, USA, 1967, prepared by E. D. Goldfield. Washington, D.C., G.P.O., 1966.

If you wish to dispose of your private libraries of texts and journals, call the Library of the Academy of Medicine of New Jersey first (201-748-3430). The library needs frequently used items as well as the rarer ones.

Electrocardiography By Telephone

The heartbeats of patients at Perth Amboy General Hospital are being sent over telephone lines to a nearby doctor's office for instant analysis in situations where time is of the essence. The link between the patient's bedside and the doctor's office is a regular telephone line connecting two identical electrocardiogram units. Believe it or not, special Data-Phone equipment developed by Bell Telephone Laboratories makes it possible to dial the doctor's telephone number and transmit electrocardiograms over the telephone network.

The heartbeats, measured by an electrocardiogram at the bedside, are converted into audio signals for telephone transmission. At the doctor's office, the audio signals are turned back into an exact graphic replica of the electrocardiogram.

Perth Amboy General Hospital is the first medical facility in our state to use this Data-Phone equipment. The communications network includes a portable transmitting unit at the hospital and a receiving unit at the professional offices of the hospital's chief of electrocardiography, Dr. Edward Margaretten. He also has another receiving unit at his home in Perth Amboy. This permits him to be on 24-hour call at the hospital.

The data set amplifies the voltages and converts them into audible sound waves of variable pitch to be transmitted over the telephone network. This was first used in 1962 to transmit an electrocardiogram from Africa to California. The patient was the movie actor, Edward G. Robinson, on location on a remote mountain near Aiusha. A doctor in Nairobi flew to Robinson's camp with the special data equipment and transmitted the electrocardiogram over telephone lines to a cardiologist in Los Angeles.

Proposed Revision of the Constitution

The following proposed revision to the Constitution was approved by the House of Delegates at the 1967 Annual Meeting and will be presented for final approval at the 1968 Annual Meeting in May. It is herewith published in full, in compliance with the Constitutional provision to that effect.

Constitution

Article VI — Board of Trustees

Current	Proposed
The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members—at least two (2) from each judicial district, and who shall each be elected for a term of three (3) years, such term to commence upon expiration of the term of the then incumbent.	The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and *elected Trustees*—at least two (2) from each judicial district *for a membership up to one thousand (1,000); each judicial district shall be entitled to one (1) additional Trustee for each additional one thousand (1,000) members, or major fraction thereof, computed as of December 31. The term of elected Trustees shall be for* three (3) years, such term to commence upon expiration of the term of the then incumbent.
Any member may be elected a Trustee for a maximum of three (3) full terms.	SAME
At the first election of Officers following the adoption of this Constitution, three (3) members shall be elected for a period of one (1) year; four (4) members for a period of two (2) years; four (4) members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three (3) years each.	SAME

Cited For Civil Defense Accomplishments

Nine persons were honored in Miami last month for their contributions to health and disaster preparedness at the Annual Conference of the United States Civil Defense Council. Seven physicians were presented the Pfizer Award of Merit, sponsored by Pfizer Laboratories. The United States Civil Defense Council is an organization of city and county civil defense directors.

Council President Peter C. McGillivray and J. Paul Jones, M.D., Associate Medical Director of Pfizer Laboratories, presented plaques to the award winners at a citation luncheon at the Deauville Hotel. One of the laureates was Jack R. Karel, M.D. of Hillside, New Jersey. Dr. Karel is in the practice of pediatrics. He has been medical coordinator of Union County Civil Defense since May 1955 to the present. In 1963 he was appointed county deputy coordinator of Union County Civil Defense Council.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of November:

	November 1967	November 1966
Aseptic Meningitis	13	7
Encephalitis, primary	0	1
Encephalitis, post-infectious	1	3
Hepatitis, Total	167	80
Infectious and unknown	146	65
Serum	21	15
Malaria (servicemen)	11	*<1
Meningococcal Meningitis	6	* 11
Rocky Mountain spotted fever	0	* 1
Primary Syphilis	45	* 55
Salmonella	79	46
Shigella	2	* 7

Hospital Infections

The Division of Preventable Diseases has become more active in helping hospitals establish effective methods of reporting and controlling hospital infections. Hospitals have become more aware of "nosocomial" (hospital acquired) infections.

The increased incidence of antibiotic-resistant bacteria and a more susceptible population of chronic disease patients have been factors for this increased awareness. An important tool in meeting this problem is an active surveillance system enabling hospitals to follow the infection rate per floor or service per month. By observing an increase in hospital infection rate over the established baseline, one can institute measures before a problem reaches epidemic levels.

An example where this system was helpful is as follows: a New Jersey hospital which undertook this system had an infection rate of zero to 2 per cent per month in their newborn nursery. On the subsequent months the infection rate rose to 5 per cent in the newborn nursery including one death due to meningitis from *proteus mirabilis*. There was no increase elsewhere in the hospital. Environmental and skin cultures were then performed, and an aspirator tubing was found to be contamined with proteus.

On January 25, 1968, a seminar on Hospital Infections Controls will be held to discuss methods of surveillance in New Jersey hospitals, legal responsibilities of phsyicians and hospitals to report hospital infections, the bacterial environment of hospitals, and isolation technics. All hospital administrators have been notified of this conference.

Revised Birth, Death, and Fetal Death Forms

By now, revised birth, death, and fetal death certificate forms have been distributed to every hospital administrator, local registrars of vital statistics, and funeral homes. These should now be used.

Measles

Measles still persists in New Jersey and Essex is one of the few counties in the United States to report over ten cases during October. Measles eradication should be our goal. Through the State Vaccination Program assistance will be given to municipalities which want to do an immunization program. The following is a four point program for the practical eradication of measles in New Jersey.

1. Routine immunization of all children when they are one year old.

2. Immunization of any susceptible children found in kindergarten through third grade.

3. Prompt reporting of measles by private physicians, health departments, and school nurses.

4. Crash immunization programs in communities where epidemics exist.

Hepatitis

The increase in number of cases of hepatitis reported was due to an investigation in Bergen County. Sixty-four previously unreported cases were found in a survey of hospital record rooms. These unreported cases represented 60 per cent of the hospitalized cases of hepatitis in Bergen County. It is assumed that presently this is representative of other counties in New Jersey. Of the 143 cases of hepatitis reported in Bergen County for the first ten months of the year, 27 were associated with parenteral narcotics.

* This figure is approximated for the total number of cases reported in 1966.

Medicine Needs More Negroes

A national awards program to encourage more Negroes to study medicine is a recommendation of a conference reported in the Journal of the American Medical Association, October 16, 1967. Also urged are efforts to strengthen the teaching of premedical sciences at the predominantly Negro colleges.

The report is from a 1967 conference sponsored by the Josiah Macy, Jr., Foundation, New York City, with the cooperation of National Medical Fellowships, Inc. The theme of the study was that, "Negroes represent one of the large untapped sources of personnel for medicine." Negroes constitute 11 per cent of the United States population, but only 3 per cent of the nation's physicians. Only 6 per cent of college-age Negroes attend college, and most of them are in the predominantly Negro colleges, where the dropout rate averages over 50 per cent. Negro women especially "represent a great potential source of Negro medical school applicants."

Other recommendations:

The two predominantly Negro medical schools should establish premedical programs — Howard with the liberal arts college of Howard University, Washington, D.C., and Meharry with its neighbor, Fisk University, Nashville, Tennessee.

Each medical school "should move aggressively" to salvage Negro applicants who are not adequately qualified for the study of medicine. Programs should be established for these students at a liberal arts college, and then continued support provided at medical school.

The Negro has special problems in the study of medicine, the conference recognized. "Moving from the campus of a predominantly Negro college to a medical school in which practically all of the other students and the faculty are white presents severe social problems which, when combined with marginal preparation, may prove too much for the student."

The Negro student should receive sufficient support from the adminitration, the faculty, and especially his classmates, the report said. It might be advisable to spread the work of the freshman year in medical school over a longer period, the conference suggested. Special summer programs might allow students to test their abilities in a single course, such as anatomy, and at the same time acquire a sense of security in the environment of the medical school.

"In all discussions, the mood of (conference) participants indicated that there should be a significantly larger number of Negroes in medicine, that there are programs that can prepare larger numbers of Negroes for the study of medicine, and that these programs should be established now," the report said.

The authors are John Z. Bowers, M.D., Lee Cogan, M.A., and E. Lovell Becker, M.D., of the Macy Foundation staff, New York.

Psychiatric Clinic In East Orange

Any New Jersey resident needing psychiatric consultation or therapy may be referred to the clinic of the New Jersey College of Medicine, 88 Ross Street, East Orange. Fees are charged in accord with the family's ability to pay. The clinic is open every week-day from 9 a.m. to 12 noon. For an appointment, phone (201) 672-6660. This is an adult clinic and the minimum age for patients is fourteen.

One Poison To Fight Another

Use of LSD-25 in a single dose test study of chronic alcoholic patients at the Lexington Veterans Administration Hospital is reported as leading to improvement in 67 per cent of the cases. Increased dosage will be tried with more tests because the first group showed patients receiving higher dosage had more significant improvement.

These findings were reported by a team of Veterans Administration doctors including Murray F. Ables, M.D., chief of psychiatry at the VA Hospital, and Erling W. Eng, Ph.D., of its psychology department.

LSD quieted the patients so they were more receptive to the usual therapy. The doctors worked on the theory that alcoholism is symptomatic of an emotional disorder arising from an individual's inability to experience and use significant feelings that provide meaning, motivation, and gratification to life.

One hundred and twenty-two patients participated in the initial LSD treatment phase which lasted two weeks. For three days before and after taking LSD all tranquilizing and other medications were stopped. Patients were assigned to group living so they could compare notes on their experiences while under LSD. They were divided into groups of about six.

The actual LSD session lasted eight hours. It was held under supervised conditions. The VA team described the medical attendants as having a "relaxed and permissive" attitude. It was held in a pleasantly appointed room. There was serious music, meaningful pictures, mirrors, flowers, and eyeshades to facilitate the patients' surrender to the flow of changing effects, images, and ideas. They had personal mementos with them. Total abstinence from liquor was not stressed at this session. During the week after the LSD session, group therapy was used to help patients go over their experiences before they were returned to regular treatment.

The average age of the group was 42. The group included men suffering from personality disturbances, neurosis and psychosis ranging from serious to milder mental disorders, and alcoholics with long chronic histories. The cases were measured according to health, social, and vocational adjustment as well as physical well-being. Comparisons of patient records for a year before the tests and for a year after the studies were made.

After LSD they had fewer arrests, fewer cases of delirium tremens, and fewer records of absent without leave. They averaged more days of total abstinence and more days of gainful employment. Sixty-seven per cent showed significant improvement in both alcoholism and social adjustment. No harmful side effects were noted. There were "no adverse, nor untoward physical or mental reactions," the VA team reported.

The two VA doctors concluded the LSD treatment held promise since it diminishes the frequent pessimistic conviction that the chronic alcoholic can never be cured.

Testimonials By MDs

The AMA has been deluged in recent months with irate complaints that physicians who lend the use of their names for testimonial advertisements are "prostituting the profession." The Judicial Council has reiterated its guidelines for physicians in their relations to commercial enterprises. It has considered only the advertisements in question. It did not assess the conduct of the physicians involved because (1) no charges had been brought against any physician as an individual and (2) the Council refused to impute improper motives to any of the physicians who, it felt, acted without any intent to violate ethical standards. But the council warns physicians of the consequences of providing testimonials without considering their potential impact upon the profession.

Complaints have stemmed from a rash of newspaper, Sunday supplement, and magazine advertisements and also sensationalized book jacket copy prepared by publishers.

Here is the opinion rendered by the Judicial Council:

"It is demeaning to the profession for a physician to permit the use of his name and professional status in the promotion of commercial enterprises. A physician may freely engage in business ventures outside the practice of medicine. However, out of respect for his profession, she should not allow his name or the prestige of his professional status as a physician to be used in the promotion of commercial enterprises."

Tobacco Research Still Going On

Is smoking a psychological addiction with deadly overtones or is it just a bad habit?

The best estimate of clinicians and scientists in the field is that cigarettes are a health hazard. But we don't have the data to establish why and how. The problem is one that must be answered at the cellular and molecular level. What effect is produced by the molecules that constitute cigarette smoke on the molecules that make up human cells?

For the past three years, wide ranging research into many questions at this level has been sponsored by the American Medical Association Education and Research Foundation. But direct and incontrovertible evidence for a cause and effect relationship between smoking and disease—including cancer, respiratory and cardiovascular disease—is difficult to obtain. Nevertheless, the program has already met with a degree of success.

In the past, research into the effects of smoking has often been retrospective in nature—attempting to correlate certain diseases with smoking patterns on a statistical basis. There was, however, only spotty interest among scientists in laboratory investigation of the questions posed by the statistics. Dr. Seevers, chairman of Pharmacology at the University of Michigan, said that grants provided under the AMA-ERF program are designed to change this by making it possible for scientists to undertake long-range studies. "Our goal has been to stimulate such interest among established researchers," he said. The decision to include cardiovascular and respiratory research in the program along with cancer. he explained, was based on the fact that certain respiratory and circulatory diseases show the same statistical relationship to smoking as cancer, and at the same time, are more prevalent than cancer.

The Project for Research on Tobacco and Health was initiated by the AMA House of Delegates as an adjunct to its educational campaign to discourage the use of toxic materials—including tobacco—among young people. However, we all know that statistical tabulations alone are not enough to dissuade smokers from their habit. The mechanisms by which tobacco smoke attacks the body, and the chemical agents responsible for the damage would have to be defined if any educational campaign were to be successful.

Much of the support for the research project was furnished by the tobacco industry itself, which pledged $10,000,000 over a five-year period. Industry interest was in settling once and for all the question of whether smoking is the cause of certain diseases. Tobacco firms wanted to know if smoking *was* implicated in disease, was it due to some specific agent or agents in the tobacco which could be removed from the smoke.

As Dr. Seevers explained: "While the medical profession and tobacco industry have somewhat divergent reasons for promoting tobacco research, both are committed to basic scientific research as the best means of developing specific answers to the questions raised by our smoking population. Certainly there are no scientific data that would contradict the basic tenets of the Surgeon General's report. I believe very few, if any, of the scientists working under this program would advise anyone to smoke."

For Childhood Asthma They Blame The Mother

Many psychiatrists believe that they know the primary cause of childhood asthma: the mother. They say that something in the mother's personality sets off the child's hidden fears and anxieties. This produces allergic reactions in the child which constrict the bronchial tubes and make breathing difficult.

What kind of woman is involved? Fourteen psychiatrists, pediatricians, and psychologists were asked to choose from among 100 definitions of the asthmatogenic (asthma-causing)

mother. "On the whole," the report said, "clinicians agree that the asthmatogenic mother is concerned with her own adequacy, is self-defensive, protective of others, sensitive to demands, in need of reassurance from others, irritable, and tends to feel guilty." The experts tended to group mothers according to three factors: (1) the "deprived" mother who is an anxious, self-pitying woman with meager resources for coping with stress, (2) the "achievement-oriented" mother who has a high level of aspiration for herself and others, and (3) the "assertive" mother who is impulsive, expressive, controlling, and oriented toward power assertion.

These descriptions most fit the three types, the clinicians said:

Type 1 — is basically anxious, feels cheated and victimized by life, is self-pitying, creates and exploits dependency in people, is subtly negativistic, and tends to undermine and obstruct or sabotage.

Type 2 — is anxious, vulnerable to real or fancied threat, and is generally fearful; has high aspirations for self, and is concerned with her adequacy as a person.

Type 3 — is talkative and is facially or gesturally expressive; is self-dramatizing and histrionic. This woman is usually protective of those close to her, behaves in an assertive fashion, creates and exploits dependency in people, has a rapid personal tempo, and behaves and acts quickly.

Characteristic of a "Type 2" mother is verbal fluency, a tendency to perceive many different contexts in sexual terms, a sensitivity to anything that could be construed as a demand, and a readiness to feel guilty. "Type 1" mothers, on the other hand, have doubts about their personal adequacy. They keep people at a distance and avoid close relationships. Such a mother is sensitive to anything that could be construed as criticism.

The clinicians agreed in describing the asthmatogenic mother as not calm and relaxed, not submissive, not skilled in the social technics of play and humor, and as neither rebellious nor nonconforming. The authors stress, however, that asthma is a complex phenomenon. Its cause cannot entirely be blamed on the mother. In some children, particularly those of "Type 3" mothers, the children's physical makeup seemed to be more a cause of their asthma than their psychological relationships with their mothers, the report said.

Jeanne Block, Ph.D. *et al.: Archives of General Psychiatry, December 1966.*

Career Handbook For New MDs

Remarkable changes have occurred in patterns of medical practice — the enormous expansion of professional and occupational resources on the allied health team and the explosive growth of community health services involved in total health care within the past generation. Yet, few changes have been made in the medical school curriculum to help prepare the new physician to grasp, appreciate, and meet these accelerating socio-economic challenges once he enters practice.

As a step toward surmounting this educational void, the American Medical Association has developed a new publication, *The Physician's Career,* a 99-page handbook intended as a teaching outline on medical practice and community relations for physicians and medical students.

More than two years in the making, *The Physician's Career* was the direct result of suggestions made at recent meetings of the House of Delegates that teaching outlines of informative material on medical ethics, medical civics, and socio-economic aspects of medical practice be provided to medical schools and medical societies for orienting students and recent graduates to non-scientific aspects of the physician's career.

Fifteen AMA departments and a task force of staff consultants cooperated in producing *The Physician's Career,* the most significant publication covering this broad subject since Joseph Garland, M.D., Boston, introduced *The Physician and His Practice* in 1954. Henry F. Howe, M.D., Director of the Department of Occupational Health, served as coordinating editor.

Prepared in narrative outline form, *The Physician's Career* is comprised of 15 chapters, divided into two parts — The Practice of Medicine and The Physician in the Total Community. The handbook focuses upon the sharp transition which has occurred since two generations ago when the unaided physician was almost the only health resource in the community. It calls attention to the fact that the short-term general hospital, once a place of last refuge for the terminally ill, has emerged into a highly organized, complex institution serving as a center of medical practice and providing the supporting services demanded by modern medical care. A major change, it points out, is the rapid evolution of group practice. Since 1948, when 3,493 physicians practiced in 368 groups, the number in group practice had more than septupled to approximately 26,000 by 1965 and is continuing to accelerate, according to preliminary information gathered in a detailed survey now being conducted by the AMA.

Chapter topics of Part One are Patterns of Medical Practice, Licensure and Accreditations, Organizations of the Health Professions, Medical Ethics, Medical Staff Organization and Responsibilities, Teaching and Research, Business Aspects of Medical Practice, and Medicolegal Obligations and Relations. Chapter topics of Part Two are Community Health Services, Voluntary Health Agencies, Governmental Health Programs, The Modern Public Health Movement, Voluntary Health Insurance and Prepayment Plans, Medical Cultism and Quackery, and Personal, Family, and Civic Responsibilities.

The AMA is encouraging state and county medical societies to utilize *The Physician's Career* as a springboard of ideas for orientation seminars for newly installed members. Copies are being provided free to members of this year's senior medical school classes.

Single copies are available at 75 cents each from the AMA Order Department. A reduced price of 45 cents a copy has been set for medical students, interns, and residents.

X-Ray's New Mini Anode

Dr. Alma Dea Morani, Professor of Clinical Surgery at Women's Medical College recently demonstrated a new x-ray anode, no longer than a tongue depressor, which permits the radiologic examination of anatomic areas formerly difficult to reach. "Inserted in the mouth, for example, the anode permits all organs, fractures, inflammations and growths to be seen on a single film, with magnification and fine detail," Dr. Morani says.

Dr. Morani developed the new machine called *Panoramix* with her colleague, Dr. Jacob Gershon-Cohen, Professor of Research Radiology at Temple University. In effect, the device is a miniature roentgen tube with an extended anode, it is small enough to be inserted in the tiniest body openings, including sinuses, joint spaces, rectal and vaginal orifices.

An x-ray beam is delivered over a 270-degree arc, giving a detailed panoramic view of bone and tissue. Inserted in the mouth, for instance, it is possible to obtain a single-plane picture showing teeth, baxilla, mandible, and the status of all supportive structures with a single exposure. Panoramix radiography requires fewer exposures, thus reducing radiation dosage. Magnification is twice that in conventional x-rays.

The device should be especially useful in the early detection of prostate cancer. It will offer aid to surgeons treating injuries or diseases of the facial bones.

AMA's Health Education Service

Keeping up with developments in the health fields would be an impossible task for school health educators if they had to pore over medical and science journals every month. Yet health education programs would be stifled if they didn't have ready access to key developments. Since January 1961, the AMA's Health Education Department has had a service aimed at achieving this end. It is the *AMA Health Education Service for Schools and Colleges,* a four-page bulletin now in its seventh year.

Some 20,000 copies are distributed to schools and colleges each month. Only one copy normally is provided to each school. Each issue contains concise articles highlighting important health news from medical journals and other science publications from throughout the world. This includes medical discoveries, research findings, warnings about health fads and phony "cures," nutrition, physical fitness, and general information concerning physical and mental health. The reference source for each article is listed, thus permitting health educators to obtain detailed information.

Subscribers to the publication make periodic evaluations to assure that it is serving its purpose. These evaluations have produced high praise for its value in health education and expressions of appreciation to the AMA for providing this service.

To be placed on the regular mailing list to receive the *Health Education Service,* an instructor concerned with school or college health education programing needs only to write to the Health Education Department of the AMA. Medical Societies and auxiliaries can fulfill a community service role by having an appropriate representative query local school officials to determine whether their schools wish to be added to the complimentary subscription list, if they are not already receiving the service. The service is sent only to schools, not individuals. Schools, may reproduce the service locally, with credit to AMA, should they need extra copies.

Sex and San Francisco

Entrapped by the rigidity of a puritan ethic, millions of Americans are unable to communicate about matters concerning human sexuality. *Semantics and Sexuality,* a three-day forum and workshop presented by San Francisco State College and the Pacific Medical Center, will address itself to these problems of communication in our society.

Featuring Dr. Lester Kirkendall of Oregon State University and S. I. Hayakawa, the well-known semanticist, the program is scheduled for February 23, 24, and 25 at San Francisco's Fairmont Hotel. Other speakers include Drs. Jerold Lowenstein and Albert Long of the Pacific Medical Center; Anthropologists Daniel Crowley from the University of California at Davis, and Herbert Williams from San Francisco State College, Lester Kinsolving, Episcopal priest and religion correspondent to the San Francisco Chronicle, and other specialists in the fields of medicine and the social sciences. For more details, write to the Faculty Program Center, San Francisco State College, 1600 Holloway Avenue, San Francisco, California 94132.

MSNJ Scientific Exhibits

Members of The Medical Society of New Jersey are invited to participate in the Scientific Exhibits at the 202nd Annual Meeting, May 18 to 22, 1968, Haddon Hall, Atlantic City. Exhibits will open at noon on Sunday, May 19, and close at noon on Wednesday, May 22. The hours on Monday and Tuesday will be from 9 a.m. to 5 p.m. Applications may be obtained from the Executive Offices in Trenton, Mrs. Marion Walton, Convention Manager.

ANNOUNCEMENTS

Infections in Hospitals

All physicians, nurses, and others involved in control of infections are invited to participate in a seminar on the subject on Thursday morning, January 25, 1968. The colloquium will be held at the New Jersey Hospital Association building on Highway 206, four miles north of Princeton, or fourteen miles south of Somerville. This program is cosponsored by The Medical Society of New Jersey, the State Health Department, and the New Jersey Hospital Association. The conference will open promptly at 9:30 a.m.

Medical Colloquium In Philadelphia

The Annual Postgraduate Institute of the Philadelphia County Medical Society will be held February 20-23, 1968 at the Bellevue-Stratford Hotel. The program will cover topics of current interest to practicing physicians.

The meeting is accepted for credit by the American Academy of General Practice. The Director is Robert L. Mayock, M.D., 2100 Spring Garden Street, Philadelphia, Pennsylvania, 19130. A copy of the program will be mailed on request to Dr. Mayock.

Joint R.N.-M.D. Session

Nurses are invited to the American College of Surgeons Sectional Meeting March 11 to 13, 1968, in Williamsburg, Virginia. As guests of the College, nurses pay no registration fee. This joint physician-nurse scientific program, inaugurated in 1955, was a success from the start. Broader professional participation, with its exchange of ideas, has helped both doctors and nurses keep pace with technologic and scientific advances and better meet their responsibilities to the public.

"In this 1968 meeting," states Mrs. Ina Love Williams, chairman of the Nurses Program Committee, "we will review surgical advances, technics and procedures, personnel problems facing nurses, changes in the nurses' role, adequate communications, intensive care of surgical patients, and doctors' and nurses' experiences aboard hospital ships."

Program details and housing forms for this meeting in historic Williamsburg are available from College headquarters, 55 East Erie Street, Chicago 60611

Industrial Medicine Colloquium

April 22 to 25 is the date, San Francisco is the place, and industrial medicine is the topic. There will exhibits, papers, panel discussions, and moving picture films on all aspects of industrial medicine and surgery, safety engineering, and public health in industry. For details write to the Industrial Health Conference at 55 East Washington Street, Chicago 60602.

Scientific Meetings In the Western Pacific

The International College of Surgeons is sponsoring four consecutive scientific meetings beginning September 28, 1968 in Honolulu. Persons who attend are then invited to continue to the Biennial International Congress, which will be held from October 3 to 13 in Tokyo. The scientific program then moves to Hong Kong, Manila, and Bangkok, and finally there will be an around-the-world study tour, visiting in India, Egypt, Israel, and Greece. The seminar terminates in New York on November 11. For further information, write to the International College of Surgeons, 230 North Michigan Avenue, Chicago, Illinois 60601.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1968
January

9 **The Academy of Medicine of New Jersey, Section on Dentistry**
Fairleigh Dickinson University School of Dentistry, Teaneck

9 **Bergen County Medical Society**

10 **Camden County Medical Society**
"Current Medical Research with Immediate Clinical Significance"

10 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Clinical Applications of New Concepts of Kinetics of Neutophilip Leukocytes"

10 **Ocean County Medical Society**

10 **Gloucester County Tuberculosis and Health Association**

11 **Essex County Medical Society**

11 **The Academy of Medicine of New Jersey, Section on Orthopedics**
Hospital Center at Orange
"Diseases of Joints"

12 **Cooper Hospital**
Camden
"Use of Psychology in the Care of the Chronically Ill Patient"

15 **St. Barnabas Medical Center Department of Anesthesiology**
Livingston
"Progress in the Development of New Neuromuscular Blocking Agents"

17 **Middlesex County Medical Society**

18 **Morris County Medical Society**

18 **Gloucester County Medical Society**

18 **The Academy of Medicine of New Jersey, Section on Urology**
Mayfair Farms, West Orange
"The Urologists' Role in the Diagnosis and Management of Hypertension"

19 **Cooper Hospital**
Camden
"Diagnostic Procedures in the Selection of Patients for Cardiac Surgery"

20 **Industrial Medical Association of New Jersey**
The Pines, Metuchen
Annual Dinner-Dance

24 **Saint Elizabeth Hospital**
Elizabeth
"Family Life"

24 **Princeton Hospital**
Princeton
"Current Concepts of Abortion"

24 **Morristown Memorial Hospital**
Morristown
"Current Status of Antihypertensive Therapy and its Effects on the Natural History of Essential Hypertension"

26 **Cooper Hospital**
Camden
"Clinical Aspects of Liver Disease"

30 **Cape May County Medical Society**

31 **Essex County Heart Association and Academy of Medicine**
Mutual Benefit Life Insurance Company, Newark
"Operable Heart Disease"

31 **Princeton Hospital**
Princeton
"Poisonous Plants"

31 **The Academy of Medicine of New Jersey, Section on Internal Medicine**
Morristown Memorial Hospital

Morristown
"Rehabilitation Medicine: Aspects of Importance to the Internist"

February

2 **Cooper Hospital**
Camden
"Crohn's Disease of the Colon"

6 **Hudson County Medical Society**
"Models of the Heart in Electrocardiography"

7 **The Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Morristown
"Acute and Chronic Care of the Alcoholic"

9 **Cooper Hospital**
Camden
"The Hormonal Treatment of Breast and Pelvic Cancer"

13 **Bergen County Medical Society**

13 **Cumberland County Medical Society**

14 **Gloucester County Tuberculosis and Health Association**

14 **Ocean County Medical Society**

14 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Somatic Aspects of Depression"

14 **The Academy of Medicine of New Jersey**
Middlesex General Hospital
New Brunswick
"Portal Hypertension: Physiology and Treatment"

15 **Morris County Medical Society**

15 **Gloucester County Medical Society**

16 **Cooper Hospital**
Camden
"Chemotherapy of Primary and Metastatic Malignancies"

19 **St. Barnabas Medical Center Department of Anesthesiology**
Livingston
"Pre- and Postoperative Digitalization and Diagnosis of Heast Failure in Surgical Patients"

20 **Warren County Medical Society**

20 **The Academy of Medicine of New Jersey, Section on Experimental Medicine**
Overlook Hospital, Summit

21 **Middlesex County Medical Society**

21 **The Academy of Medicine of New Jersey**
Robert Treat Hotel, Newark
Pediatric Symposium

28 **The Academy of Medicine of New Jersey**
Princeton Hospital, Princeton
Symposium — "Problems of Oral Contraceptives"

28 **New Jersey Gastroenterological Society**
Essex House, Newark

29 **Morristown Memorial Hospital**
Morristown
"Pleuropneumonia-like Organisms (PPLO) as Human Pathogens and as Biological Curiosities"

March

1 **Cooper Hospital**
Camden
"The Role of the Internist in the Treatment of the Psychotic Patient"

6 **Camden County Medical Society**
Ladies night — "Family Life Education"

6-9 **New Jersey Academy of General Practice**
Atlantic City

7 **Hudson County Medical Society**
"Current Trends in Medical Malpractice Litigation"

7-8 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Culdoscopy

8 **Cooper Hospital**
Camden
"Recently Appreciated Rheumatic Syndromes"

12 **Bergen County Medical Society**

12 **Essex County Medical Society**
Hotel Suburban, East Orange
"What Can An Office Consultant Do For You?"

13 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Islet Cell Tumors of the Pancreas and Syndromes Associated With Them"

13 **Ocean County Medical Society**

13 **Gloucester County Tuberculosis and Health Association**

13 **The Academy of Medicine of New Jersey**
Mountainside Hospital, Montclair
Symposium on Supraventricular Arrhythmias

15 **Cooper Hospital**
Camden
"Collagen Disease"

19 **The Academy of Medicine of New Jersey and American Cancer Society (New Jersey Division)**
Newcomb Hospital, Vineland
Symposum: Cancer of the Colon and Rectum

19 **Passaic County Heart Association**
Annual Meyer Notkin Lecture

20 **Middlesex County Medical Society**

21 **Morris County Medical Society**

22 **Cooper Hospital**
Camden
"When to Hospitalize the Diabetic"

23 **New Jersey State Society of Anesthesiologists**
Cherry Hill Inn, Cherry Hill
9th Annual Postgraduate Seminar

26 **Cape May County Medical Society**

27 **New Jersey Heart Association**
Annual Scientific Seminar

29 **Cooper Hospital**
Camden
"Detection and Long-Term Management of the Ambulatory Diabetic Patient"

April

2 **Hudson County Medical Society**
"Some Psychiatric Problems of Childhood and Adolescence"

5 **Cooper Hospital**
Camden
"Modern Trends in the Treatment of Leukemia"

9 **Bergen County Medical Society**

9 **Cumberland County Medical Society**

10 **Ocean County Medical Society**

10 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Biochemical Pharmacology And The Brain"

10 **Gloucester County Tuberculosis and Health Association**

12 **Cooper Hospital**
Camden
"What's New in Dermatology?"

16 **Warren County Medical Society**

17 **Middlesex County Medical Society**

17 **Newark Beth Israel Hospital**
Newark
"Mechanics and Management of Cardiogenic Shock"

18 **Morris County Medical Society**

18 **Gloucester County Medical Society**

19 **Cooper Hospital**
Camden
"Chromosome Aberration in Old Age and Malignancy"

24 **The Academy of Medicine of New Jersey**
Veterans' Administration Hospital
East Orange
Dental Symposium — "Periodontal Disease-Etiology and Treatment"

26 **Cooper Hospital**
Camden
"Immunity—Its Role in Health and Disease"

May

1 **Camden County Medical Society**

1 **Passaic County Heart Association**
Symposium on New Concepts in Cardio-Vascular Disease

7 **Hudson County Medical Society**
Election of Officers

8 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Drugs, Poisons, and Membrane Phenomena"

8 **Ocean County Medical Society**

8 **Gloucester County Tuberculosis and Health Association**

9 **Essex County Medical Society**

14 **Bergen County Medical Society**

16 **Morris County Medical Society**

16 **Gloucester County Medical Society**

18-22 **The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Annual Meeting

19 **The Academy of Medicine of New Jersey and The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Symposium on Medicine and Religion

22 **Middlesex County Medical Society**

28 **Cape May County Medical Society**

June

6-7 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Culdoscopy

11 **Cumberland County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

OBITUARIES

Dr. Alex H. Christensen

A leading Hunterdon County practitioner, Dr. Alex Hjalmar Christensen, died on September 27, 1967 at the age of 64. He was one of the state's few physicians to have long served on a municipal governing body, having for two decades been an active and beloved member of the Lebanon Borough Council. He was also the Lebanon school physician and member of the borough's Board of Health. Dr. Christensen received his M.D. at Bellevue in 1930, and was active in the affairs of the Academy of General Practice.

Dr. Mario J. DeMarco

At the untimely age of 43, Dr. Mario De Marco died suddenly on September 24, 1967. Dr. DeMarco earned his M.D. at the University of Geneva, Switzerland, in 1956. After concluding his interneship at St. Michael's Hospital in Newark, he went into practice in Newark, serving as a family doctor. Only last year Dr. DeMarco moved to Ocean County, setting up general practice in Dover Township there. Back in 1943, at the age of 19, he enlisted in the Army, was selected for officer training and within three years had become a Captain. Discharged from the Army in 1947, he returned to college, got a baccalaureate degree and then went to Switzer-

land, entering the medical school of the University of Geneva in 1952.

Dr. Leslie Ewing

One of Camden County's senior practitioners, Dr. Leslie Ewing, died on October 25, 1967 at the age of 77. Dr. Ewing received his M.D. at Jefferson Medical College, class of 1911. After completing his interneship, he entered private practice, but after five years, closed his office to accept a commission in the medical corps of the Army of the United States. He served throughout World War I and for a year thereafter, returning at the end of 1919 to reopen his office in Berlin, New Jersey. There he labored for almost half a century serving the people of southern New Jersey as a family doctor of the old school.

Dr. Everett H. Hemphill

On October 27, 1967, death came to Everett Hemphill of Haddonfield. Born in 1906, he received his baccalaureate degree at the University of Pennsylvania in 1929, and his M.D. four years later from the medical school of the same University. Dr. Hemphill was a general practitioner with special attention to cardiology, and was on the staff of the medical service at the Cooper Hospital in Camden. During World War II, he served as a captain in the medical corps of the Army of the United States.

Dr. John J. Mackin

November 9, 1967 saw the death of one of Hudson County's most useful citizens, Dr. John J. Mackin. Born in 1905, he recevied his M.D. at Columbia University's College of Physicians and Surgeons in 1932. He was, for years, a general practitioner with special interest in obstetrics. He realized from the start of his practice the importance of the emotional factor in general medicine and began to devote more of his time to psychiatry.

Dr. Mackin had a psychiatric residency at the State Hospital in Marlboro and returned to his native county where he became a pioneer in setting up mental health clinic services. He then became director of the Diagnostic Center for the Hudson County Department of Mental Hygiene.

He served as an Army psychiatrist during World War II, assigned to duty in the Pacific Theatre of Operations. He was devoted to the St. Francis Hospital in Jersey City, and finally persuaded that hospital to blue-print a psychiatric pavillion. Dr. Mackin was scheduled to become director of that pavillion.

Dr. Evelyn Z. Merrick

Evelyn Zenobia Merrick, one of Essex County's pioneer rheumatologists, died on October 17, 1967 at the age of 62. Dr. Merrick was a 1936 graduate of the Woman's Medical College of Philadelphia, and was long active in rehabilitation, orthopedics, and rheumatology. She was on the staff of the Orange Hospital Center, and was active in the affairs of the New Jersey Rheumatism Association.

Dr. Ralph I. Mond

Death, at the age of 41, cut short a promising career in internal medicine with the passing that day of Ralph Ira Mond, M.D. Dr. Mond was a board-diplomate in internal medicine. He practiced in Springfield and was on the medical service at the Overlook Hospital in Summit. Dr. Mond received his M.D. at Bellevue in 1949 at the age of 23, the youngest in his class. He was active in the work of the American College of Physicians.

Dr. Michael Romano

On December 1st, at the tragically untimely age of 59, death took Michael J. Romano, a Fair Lawn surgeon. Born in Yonkers in 1908, Dr. Romano received his medical degree at Loyola in 1936. After internship, he did general practice in Bergen County with especial attention to surgery. He was active in the affairs of the Bergen County Medical Society. Dr. Romano was on the surgical service of the Valley Hospital in Ridgewood.

Dr. Raphael Schillinger

Born in 1895, Raphael Schillinger, M.D. was a board-certified otolgist and laryngoloist who practiced in Westfield. He was active in the affairs of the Union County Medical Society. He received his M.D. at Bellevue in 1918 and immediately entered the medical corps of our Army. Following this service, he had a brief period as a family doctor, and then obtained advanced training in ophthalmology and otolaryngology. He retained his interest in military medicine too and worked with the Society of Military Surgeons on several projects in that field. Dr. Schillinger was on the staffs of both the Children's Specialized Hospital in Westfield and the Rahway General Hospital. Dr. Schillinger died on October 27, 1967.

Dr. Charles I. Silk

One of New Jersey's senior medical practitioners, Dr. Charles I. Silk, died at the age of 94, on November 16, 1967. Dr. Silk was a genuine pioneer in the struggle against respiratory diseases. Cornell awarded him an M.D. in 1900 — the year that tuberculosis was the number one cause of death in our state. He had been born in Hungary in 1874, and was brought to the United States at the age of fourteen. After a brief residence in New York City, he moved to Perth Amboy, then a small town of 5,000. He opened an office in his new hometown in 1901 and there he remained, serving the people of the Raritan Valley for more than half a century.

Dr. Silk founded the Kiddie-Keep-Well Camp, a pacemaker for "health camps" for urban children, soon copied throughout the country. He became president of the Middlesex County Tuberculosis League, chairman of the city Board of Health, and a consultant at both Roosevelt and St. Peter's Hospitals. The headquarters of the county respiratory disease organization in New Brunswick is called the Silk Building, in his memory. He was active in civic and taxpayers' groups, in his Temple, and several service organizations.

Rudolph E. Warnecke

At a time, and in an area, where specialization had become fashionable, Rudolph Warnecke remained the dedicated family doctor. Born in 1902, he died on September 20, 1967. He received his M.D. degree at Hahnemann in 1941. On completing his interneship, he applied for military service and entered the medical corps of the Army of the United States as a first lieutenant. He was promoted to Captain the following year and had attained the rank of Major when he was demobilized in 1946. Dr. Warnecke then came to East Orange where he developed a general practice. He was affiliated with St. Barnabas and the East Orange General Hospitals.

Dr. Anthony Yurevich

New Jersey lost one of its senior physicians on October 3, 1967, with the death that day of Anthony Yurevich. Dr. Yurevich was born in Russia in 1883 and received his M.D. degree at the medical school of the University of Moscow in 1911. After hostilities ceased in 1919, he emigrated to the USA, passed the New Jersey State Boards and set up a family practice in central New Jersey. He remained a rural general practitioner for four decades, serving the people of Ocean County from his office in Lakewood. Dr. Yurevich retired from active practice in 1960 at the age of 77.

Emergency Call Number For State Health Department

Put this number near your phone: (609) 392-2020.

That is the "after hours" emergency number for our State Health Department. Use it on holidays, Saturdays, Sundays, and after 5 p.m. on other days. The answering service will then route your call to the physician, veterinarian, sanitarian, or technician on call for your particular problem.

(609) 392-2020

BOOK REVIEWS

Pathology. Stanley L. Robbins, M.D. Ed. 3. Philadelphia, 1967, Saunders. Pp. 1434. Illustrated. (Single Volume, $20.50; Two Volume Set, $25)

Robbins has updated and expanded his excellent introductory textbook on pathology, and it is most welcome. Primarily written for medical students and their mentors, this book has definite merit as a reference work, especially for physicians with only a limited exposure in pathology. In the first part of the book, general dynamic principles of pathology are presented. This includes injury and death of cells, inflammation, neoplasia, metabolic disorders, infectious diseases, and diseases of immune origin. This last chapter has been completely rewritten since the previous edition. Also, two new chapters have been added: Diseases of Aging, and Genetics and Disease.

The second part of the book shows how these principles are applied to disease processes in the various systems: respiratory, gastrointestinal, urinary, genital, endocrine, integumentary, and nervous. The heart, blood vessels, blood, bone marrow, liver, pancreas, kidney, and breast are afforded separate chapters.

Written in a clear, concise style which eliminates ambiguity and emphasizes salient points, this makes enjoyable reading in a potentially difficult subject. Two hundred seventy pages have been added since the previous edition and the numerous references at the end of each chapter have been updated to 1966; many since the previous edition.

Robbins' treatment of certain controversial subjects as established fact, weakens the overall excellence of the book. For example, he states that there is no reasonable doubt that all overt carcinomas of the uterine cervix begin as *in-situ* lesions. In truth, however, many respected pathologists are of the opinion that invasive squamous cell carcinoma of the cervix may arise in one of two ways: as progression of an *in-situ* lesion, or *de novo*. There was no review of the effects of oral contraceptives on various organs, especially the genital tract and breast. Iatrogenic disease is given only minor coverage. One hopes that these areas are under preparation for the next edition.

The book is well made and durable. The illustrations, in excess of 1000, are excellent. The 1 or 2 volume forms of the book are identical in content. At $20.50, this is an excellent investment.

ALLAN LAZAR, M.D.

A Treatise on the Human Teeth. R. C. Skinner. (First published 1801) 1967 edition by Argosy Antiquarian, 116 East 59 Street, New York City 10022. Pp. 28 plus 11 pp. of front matter. With 2 plates. ($10.00)

In 1788 a young British dentist came to America. He had learned his profession as an apprentice—the usual route in those days. He set up an office in Philadelphia, "Two doors below the Dock in Second Street" and advertised in the Philadelphia Federal *Gazette* that he was available and that he "engaged to cure in a few moments that excruciating pain proceeding from carious teeth, without extracting them." Three years later he moved to New York and was thereafter identified with dental surgery in that city for most of his professional life. His fee schedule showed that he charged 50¢ each for filling cavities with silver or lead foil and eliminating caries.

In 1801 he issued this volume, the first book on dentistry ever published in America. To commemorate the Centennial of the New York University College of Dentistry, the original 1801 volume was photocopied, and together with an interesting introduction by Max Geshwind, DDS, made available in this book. It offers a wonderful vignette of early 19th century dental knowledge. Most dentists then, especially the "tooth drawers" used a brutal looking instrument (illustrated in these pages) known as a turnkey, which apparently twisted the tooth out, probably leaving the roots broken and imbedded. Skinner insisted on a straight vertical draw and developed instruments for this purpose. A handsome map (apparently a reproduction of one prepared in 1791) of lower Manhatten decorates the end-pages of this little volume. This book makes an excellent gift for your friendly dentist and is a little treasure trove for all interested in the history of the healing arts.

ULYSSES M. FRANK, M.D.

A Textbook Of Clinical Psychiatry. Arthur H. Chapman, M.D. Philadelphia, 1967, Lippincott. Pp. 480. ($10.50).

It is sometimes said that a psychosis or psychoneurosis is always somebody else's fault. This depends on the concept that emotional disorders arise out of unhealthy interpersonal relationships. Dr. Chapman is a firm believer in this. Indeed, he defines psychiatry as the science which "deals with unhealthy interpersonal relationship." He points out that even organic brain syndromes are colored by the patient's pre-existing interpersonal life.

This book presents a kind of capsule of psychiatry beamed at a level somewhere between a high school course in personal adjustment and a freshman college course in psychology. Thus, mental mechanisms — paranoid thinking, for instance — are clearly described but no effort is made to suggest how these symptoms develop or how they can be explained. The chapters on legal aspects of psychiatry, on allied professions, and on the organization of psychiatric services are all pitched at a superficial level, a sort of once-over lightly. The chapter on interview technics is good, and so is the material on medication. On the whole, the text seems more appropriate for the undergraduate college than for the medical student. It will also be a serviceable text for nonprofessional people in the mental health field.

HENRY A. DAVIDSON, M.D.

Manual on Alcoholism. Edited by R. J. Shearer, M.D. Chicago, 1967, American Medical Association. Pp. 87. (Paperback—50 cents)

Perhaps one of the problems with treating the alcoholic is the conventional notion that it is a disease, and, therefore, (like pernicious anemia or a stroke) something for which the patient has no responsibility. This brief brochure lends support to the "sickness" view of alcoholism.

In 87 pages, the AMA's new manual defines alcoholism and sets out its causes. It describes the metabolism and pharmacology of alcohol, and offers suggestions on diagnosis and the physical, psychologic, and sociologic aspects of treatment. The "disease" view is reinforced by the allegation that alcoholism is associated with physical disability.

A comprehensive review of the many proposed treatment methods is not attempted. The authors avoided a "primer" approach, fearing that this would lead to a set of recipes or formulae which would preclude judgment and become outdated rapidly.

The editors arrive at a compromise. Basic general information is presented in the text, and more specific considerations are outlined in an appendix. The appendix mentions (1) "Clues" to aid in the diagnosis of alcoholism, (2) considerations in managing the hospitalized alcoholic, (3) what to do when the alcoholic enters the hospital, and (4) alcohol blood levels and intoxication.

The manuscript was approved by the AMA Council on Mental Health and its Committee on Alcoholism and Drug Dependence. ABRAHAM LEFF, M.D.

Textbook of Medicine. 12th Edition. Edited by Paul B. Beeson, M.D. and Walsh McDermott, M.D. Philadelphia, 1967, W. B. Saunders. Pp. 1738. (Single Volume, $20.50; Two Volume Set, $30)

This large book requires a large review to do it any justice. Its associate editors and list of contributors reads like a "Who-Who" of the contemporary medical world.

This textbook follows in the grand tradition of the Cecil-Loeb masterpieces of the past. The editors state that the purpose of this volume is to act as an "entry point" into the vast mass of biomedical information presently available. The size of the text reflects the huge mass of data which had to be compressed, edited and summarized while remaining stimulating and palatable to those who read it.

The medical student will find this book an excellent source of knowledge about the common diseases of the infectious group, immunoallergic syndromes, pulmonary system, cardiovascular system, kidneys, digestive system, blood forming organs, nutrition, hereditary defects, endocrine system, bone and joints, chemical toxins, environment, and the central nervous system. But, there is also to be found in these pages, many exotic diseases about which one can only read, but probably never see such as Semliki Forest virus, Ellis-Van Creveld Syndrome or angiokeratoma corporis diffusum.

The price of this book is justified in the first seven pages of the Forewards which consists of three essays by those outstanding medical-philosophers Dana W. Atchery, Frank L. Horsfall, Jr. and Renè Dubois. These short disertations represent a highly concentrated distillate of contemporary medical thinking at the highest level which should be read, digested, reread and then established as a credo of medical thought.

This volume is all solid medical material with a good index at the end and an excellent orderly table of contents. Although written as a textbook for the medical student, this book makes an excellent reference for the busy clinician or the limited specialist who wants information that is readily available and understandable. MARTIN J. ROWEN, M.D.

Atlas of Intestinal Stomas. Rupert B. Turnbull, Jr. M.D. and Frank L. Weakley, M.D. Saint Louis, 1967, C. V. Mosby Company. Pp. 207. 182 Illustrations. ($21.50)

The authors have graphically presented their large experience with abdominal stomas and the problems arising in their formation. The section relating to the history or "evolution" of ileostomy should be read by all surgeons, so they might avoid the pitfalls that earlier workers experienced with abdominal stomas.

The illustrations clearly depict in step-wise fashion the technics used in forming abdominal stomas and reveal many seemingly minor details which are responsible for the excellent results of the authors. The methods of primary maturation of all stomas at the time of surgery leads to excellent function and strictures do not result. Temporary stomas are formed in a manner which facilitates closure when the colostomy is no longer needed.

This volume should be carefully studied by surgeons treating colon disease, as it is a complete reference for all "ostomy" problems. The illustrations and legends are clear, allowing one to perform the procedure by following the diagrams. The book will also find effective use in the instructing of surgical residents, as the methods depicted are clearly described and based on extensive practical experience.

An additional chapter on the management of late stoma problems, such as skin irritation, would be of value as would a description of the irrigation technics advised by the authors for colostomy control.

BENJAMIN SCHATMAN, M.D.

Insurance For The Doctor. Harvey Sarner and Herbert C. Lassiter. Philadelphia, 1967, Saunders. Pp. 193. ($9)

A principal dilemma of the physician ("doctor" in the title of this book includes dentists and veterinarians) in private practice rests on the facts that he cannot get information in breadth about his economic problems from his individual insurance broker (who is often a specialist in one field of insurance), and is unable to get a discussion in depth from the available books on economic problems. Sarner and Lassiter provide basic information over a wider area of concern than most brokers are prepared to offer. They cover not only life, disability and accident policies, and professional and premises liability but also discuss the physician's liability and rights under social security, unemployment insurance, and workmen's compensation. Few physicians are in a position to deal intelligently with all of these fields and the book is therefore of value to almost any doctor. It would, however, be a mistake to suppose that, in a publication of this small size, it would be possible to cover any of these extensive subjects adequately. There is a large gap between insurance as discussed in the books and insurance in practice. The physician who is interested in a retirement program or in the tax aspects of insurance must expect to devote many hours of valuable time to the study of these subjects; he must define his goals and often has to modify his approaches to them. He has to review his course periodically to make the changes which alterations in circumstances due to the passage of time require. Professional liability also can become a bewilderingly complex affair.

FRED A. METTLER, M.D.



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There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

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Lomotil helps get children with diarrhea off toast and tea and back to normal diets and normal activity with gratifying dispatch. ▪ Lomotil lowers intestinal motility and permits absorption of excess fluid. This usually controls diarrhea promptly. ▪ Moreover, lowered intestinal motility achieved with Lomotil often relieves the abdominal cramps and discomfort so distressing to children.

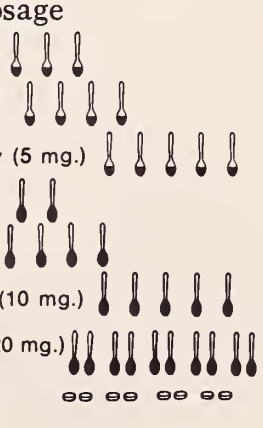
Precautions: Lomotil is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is recommended. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

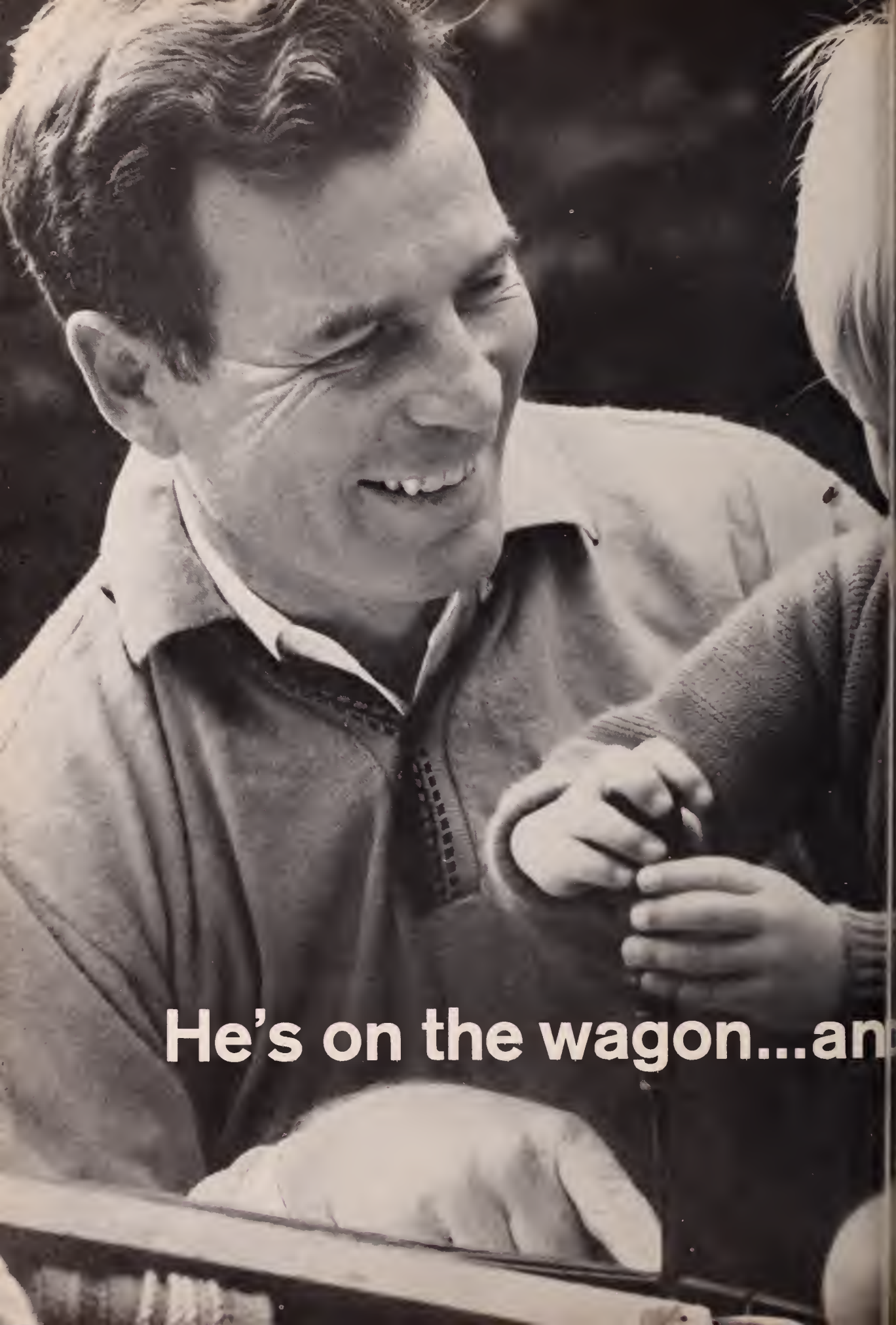
3-6 mo. . .½ tsp.* t.i.d. (3 mg.)
6-12 mo. .½ tsp. q.i.d. (4 mg.)
1-2 yr. . . .½ tsp. 5 times daily (5 mg.)
2-5 yr. . . .1 tsp. t.i.d. (6 mg.)
5-8 yr. . . .1 tsp. q.i.d. (8 mg.)
8-12 yr. . .1 tsp. 5 times daily (10 mg.)
Adults: . .2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.



*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

SEARLE *Research in the Service of Medicine*


He's on the wagon...an

low well does Vistaril relieve the symptoms that lague an alcoholic during the recovery period? octors Knott and Beard of the Alcoholic Rehailitation Unit, Tennessee Psychiatric Hospital nd Institute, recently conducted a double-blind tudy comparing Vistaril and another wellstablished antianxiety agent with placebo in 60 hronic alcoholic patients.[1]

he investigators conclude: "It was the opinion f the staff that hydroxyzine was generally more ffective than chlordiazepoxide, for the follow-g reasons: hydroxyzine was equally if not more ffective in reducing anxiety and tension and it roduced less daytime sedation...."[1] (See results n succeeding pages.)

ere is new evidence that Vistaril can ease ten-ion, allay anxiety in chronic, hospitalized alco-olic patients. *But you might also choose Vistaril or what it doesn't do.* Although not evaluated in his study, Vistaril is reported to be non-euphor-ant, and its low toxicity makes it relatively safe. est of all, Vistaril is non-habituating. To date, fter more than ten years of clinical use, there ave been no reports of dependency in patients eceiving Vistaril.

ith Vistaril, it is as easy to top therapy as it is to start.

Vistaril®
HYDROXYZINE PAMOATE)

the study:[1] Sixty chronic alcoholic patients were hospitalized and randomly assigned to one of three oral double-blind treatment regimens for three weeks. Twenty patients received hydroxyzine (Vistaril®), 100 mg. q.i.d.; twenty others were given chlordiazepoxide, 25 mg. q.i.d.; and the remaining twenty received placebo capsules q.i.d. The capsule code was not made known until after completion of the study and analysis of the data. Response was measured with a modification of the Brief Psychiatric Rating Scale as originally outlined by Overall and Gorham.* Subjects were rated daily by trained staff members.

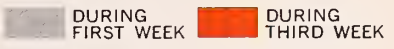
SYMPTOM RATING KEY

1=Not Present	4=Moderately Severe
2=Mild	5=Severe
3=Moderate	6=Extremely Severe

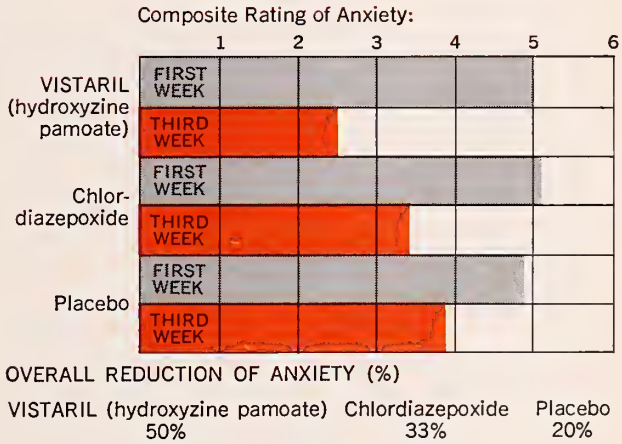
The figures which are given below represent the composite conclusions of the staff based on daily ratings during initial and final weeks of the study.

*Psychological Reports 10:799, 1962

the results'



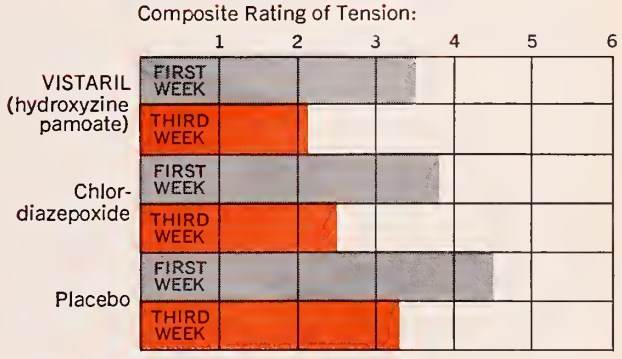
Anxiety reduced with Vistaril



OVERALL REDUCTION OF ANXIETY (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
50%	33%	20%

Tension eased with Vistaril



OVERALL REDUCTION OF TENSION (%)

VISTARIL (hydroxyzine pamoate)	Chlordiazepoxide	Placebo
40%	34%	27%

PLEASE SEE LAST PAGE FOR PRESCRIBING INFORMATION

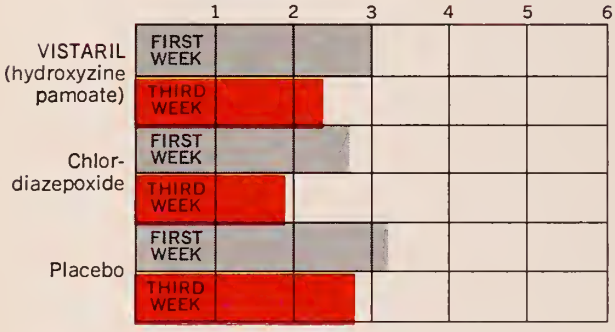
In Alcoholism...

"Both hydroxyzine and chlordiazepoxide were generally more effective than the placebo. In some aspects, hydroxyzine was superior to chlordiazepoxide, which is currently the most frequently used psychotropic drug in the management of alcoholism."[1]

DURING FIRST WEEK DURING THIRD WEEK

Depressive mood improved with chlordiazepoxide

Composite Rating of Depression:

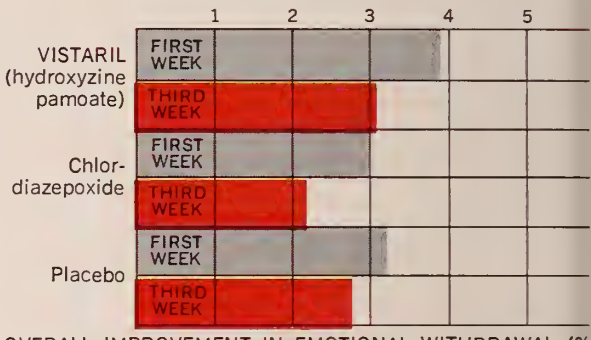


OVERALL IMPROVEMENT IN DEPRESSIVE MOOD (%)

VISTARIL (hydroxyzine pamoate) 20% | Chlordiazepoxide 30% | Placebo 13%

Emotional withdrawal counteracted with chlordiazepoxide

Composite Rating of Emotional Withdrawal:

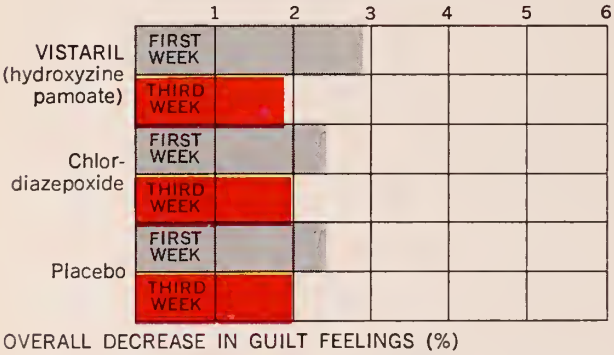


OVERALL IMPROVEMENT IN EMOTIONAL WITHDRAWAL (%

VISTARIL (hydroxyzine pamoate) 21% | Chlordiazepoxide 27% | Placeb 13%

Guilt feelings allayed with Vistaril

Composite Rating of Guilt Feelings:

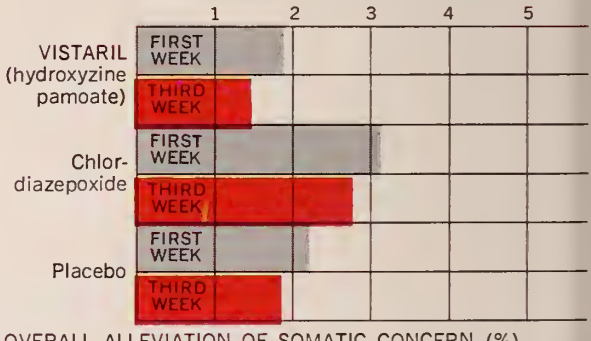


OVERALL DECREASE IN GUILT FEELINGS (%)

VISTARIL (hydroxyzine pamoate) 34% | Chlordiazepoxide 17% | Placebo 17%

Somatic concern alleviated to minor degree in each group

Composite Rating of Somatic Concern:



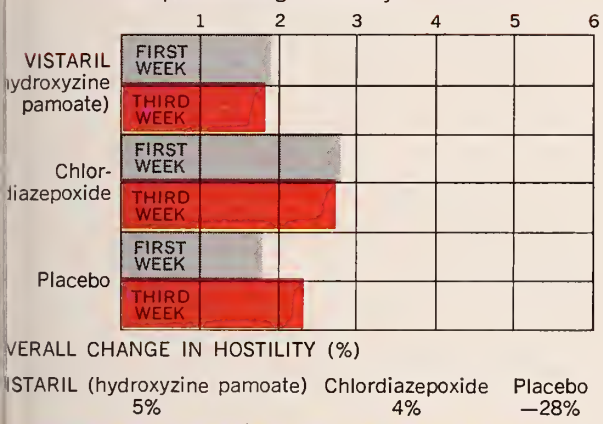
OVERALL ALLEVIATION OF SOMATIC CONCERN (%)

VISTARIL (hydroxyzine pamoate) 17% | Chlordiazepoxide 13% | Placet 14%

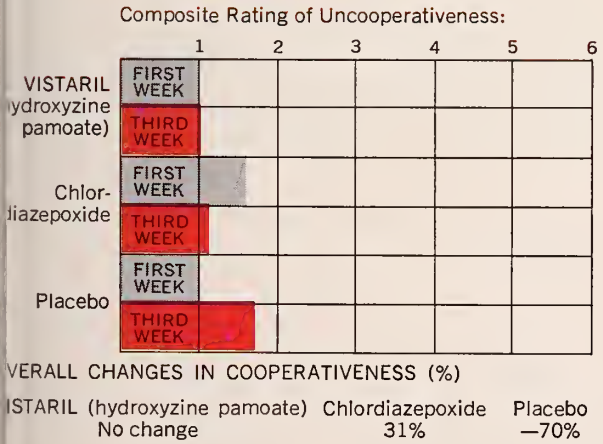
Less drowsiness with Vistaril

	Drowsiness	Dizziness	Mouth Dryness	Increased Motor Activity	Ataxia	Nausea	Comments
VISTARIL (hydroxyzine pamoate)	6 patients (mild)	3 patients (mild)	2 patients (moderate)	—	—	—	Side Effects Not Treated
Chlor-diazepoxide	10 patients (severe in 6)	4 patients (mild)	—	1 patient (moderately severe in first week but gradually subsided)	—	—	Side Effects Not Treated
Placebo	2 patients (mild)	2 patients (mild)	—	—	1 patient (mild)	2 patients (mild)	Side Effects Not Treated

Increase in hostility minimized with Vistaril and chlordiazepoxide



Cooperativeness not a significant problem



n Alcoholism...

Vistaril®

HYDROXYZINE PAMOATE)

BRIEF SUMMARY

Contraindications: Hypersensitivity to hydroxyzine. The parenteral solution, for intramuscular or intravenous use, *must not* be injected subcutaneously or intra-arterially.

Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate. Until adequate data are available to establish safety in early pregnancy, hydroxyzine is contraindicated during this period.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as narcotics and barbiturates. In conjunctive use, dosage for these drugs should be decreased, as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. The usual precautions for intramuscular injection should be followed; soft-tissue reactions have rarely been reported when proper technique has been used. Hydroxyzine parenteral solution for intramuscular use should be injected well within the body of a relatively large muscle. In adults, the preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. In children, preferably the mid-lateral muscle of the thigh. In infants and small children the upper outer quadrant of the gluteal region should only be used when necessary, as in burn patients, in order to minimize the possibility of damage to the sciatic nerve. The deltoid area should be used only if well developed, such as in certain adults and older children, and only with caution to avoid radial nerve injury. Injections should not be made in the lower and middle thirds of the upper arm. Aspiration should be done to help avoid intravascular injection. On reported intravenous injection a few instances of digital gangrene have occurred distal to the injection site, considered to be due to inadvertent intra-arterial injection or possibly periarterial extravasation. Therefore, particular caution (aspiration and site injection) should be observed to insure injection only into intact veins; avoid either intra-arterial injection or extravasation. Intravenous administration should be accomplished slowly, no faster than 25 mg. per minute, and not to exceed 100 mg. in any single dose. In order to avoid possible adverse effects it is recommended that hydroxyzine parenteral solution be diluted to at least 50 cc. with sterile normal saline and administered over a period of four minutes or more, preferably into the tubing of a running intravenous infusion.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

When this product is given intravenously undiluted, minimal amounts of intravascular hemolysis occur at the site of injection. Giving the maximum recommended intravenous dose (100 mg.) to adults results in immediate transient hemolysis with the liberation of a total of 2-3 grams of hemoglobin, which, in some individuals, can cause small amounts of hemoglobinuria. This compares with the normal red cell destruction from which approximately 8 Gm. of hemoglobin are liberated every 24 hours. If the hydroxyzine is diluted with 50 cc. of normal saline and given during a period of four minutes or more, this phenomenon does not occur.

Supply: Vistaril (hydroxyzine pamoate) Capsules: Equivalent to 25 mg., 50 mg., 100 mg. hydroxyzine HCl. Vistaril (hydroxyzine pamoate) Oral Suspension: Equivalent to 25 mg. hydroxyzine HCl per 5 cc. teaspoonful. Vistaril (hydroxyzine HCl) Parenteral Solution: 25 mg./cc.—10 cc. vial and 50 mg./cc.—2 cc. and 10 cc. vial; Isoject,® 25 and 50 mg. per cc., 1 cc. per unit.

More detailed professional information available on request.

Reference: 1. Knott, D.H. and Beard, J.D.: GP 36:118, September, 1967.

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Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A



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Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex® Sequels®

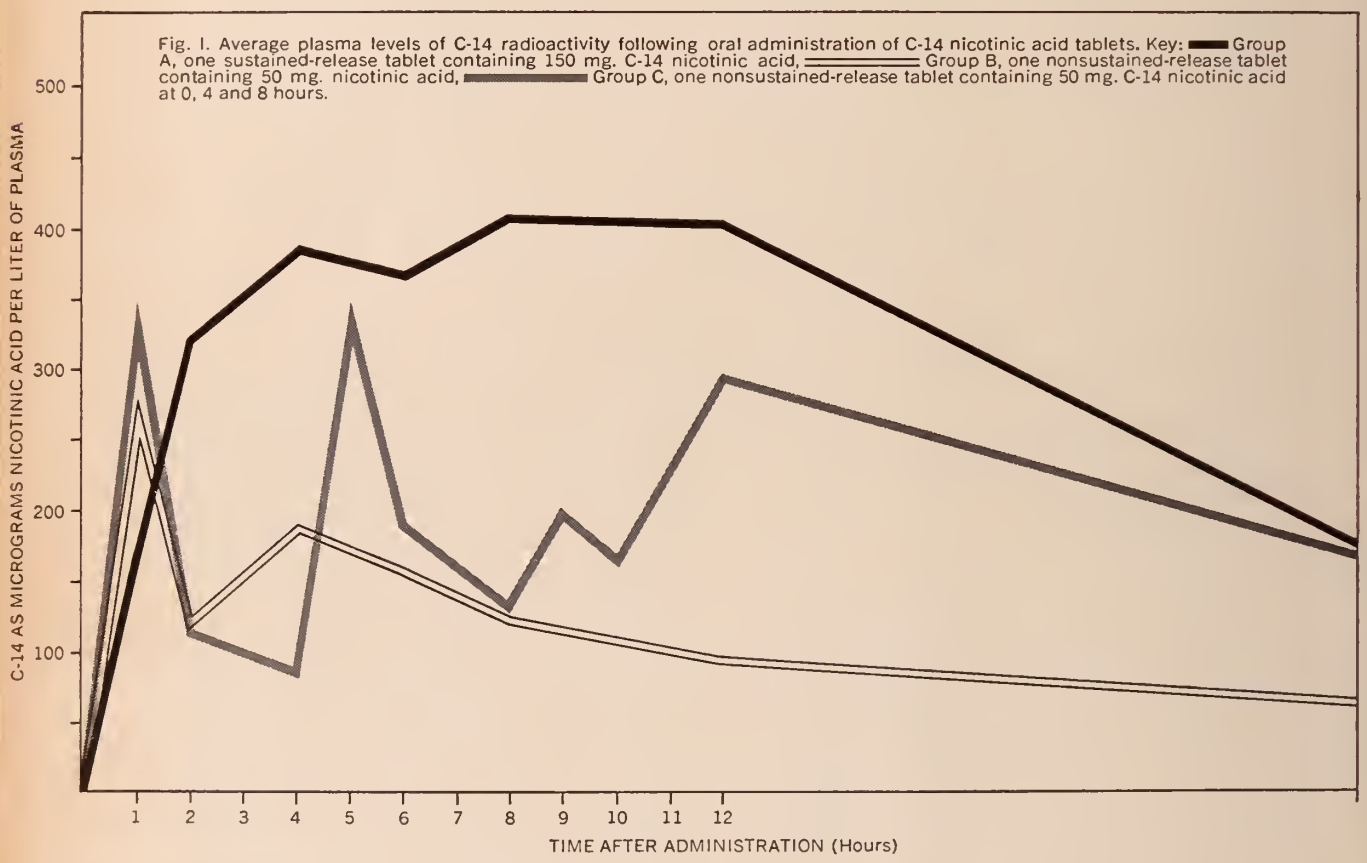
Dextro-amphetamine sulfate (15 mg.) with Meprobamate (300 mg.) **Sustained Release Capsules**

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

484-7

Sustained circulatory, respiratory and cerebral stimulation for the





(fewer absent doses by absent-minded patients)

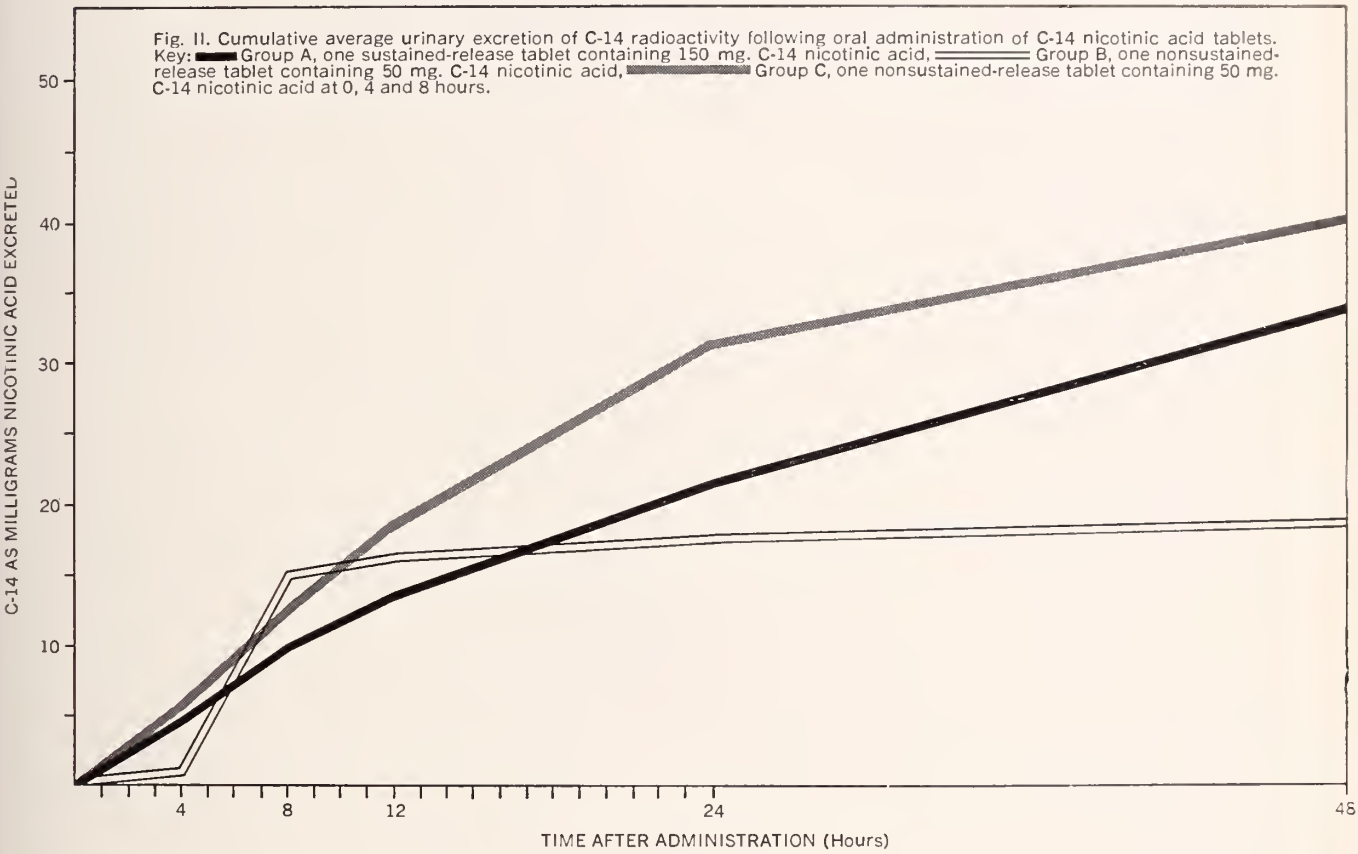
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and
Pharmaceutical Industries Corp.

Geroniazol® TT
nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet



when he just can't sleep

Tuinal

One-Half Sodium Amobarbital and
One-Half Sodium Secobarbita
supplied in ¾, 1½, and 3-grain Pulvules



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

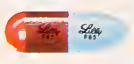
Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206

800865

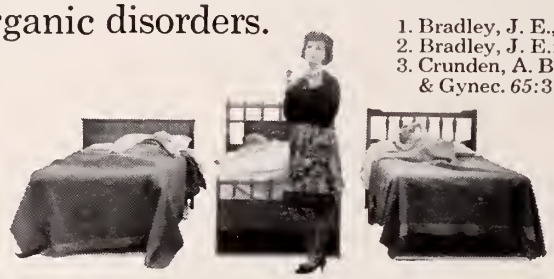
Lilly



Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



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Emetrol®
phosphorated carbohydrate solution
emesis control

Easy on the Budget...
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Tablets & Elixir
For Iron Deficiency Anemia

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brand of FERROUS GLUCONATE

BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin plus belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation. A. H. Robins Company, Richmond, Va. 23220

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All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Pheniramine maleate . . . . . 7.5 mg.
Codeine phosphate . . . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Dextromethorphan hydrobromide . 15.0 mg.
Alcohol, 1.4%

New! Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate . . . . . 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

PHOTO BY VICTOR HANO

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS



Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 yea of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, dis turbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis i schizophrenics and agitation (includ

When a milestone in life is marred by depression...



Often in the mind of the lonely, widowed, depression-prone individual, she's not gaining a daughter...she's losing a son. The occasion may be marred by such symptoms of depression as feelings of sadness, incapacity, helplessness and hopelessness.

In about 3 out of 4 cases, Tofrānil relieves symptoms of primary depression.

As maintenance therapy in primary depressive illness, it helps prevent relapse.

Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, in patients with cardiovascular disease, thyroid disorders, increased intraocular pressure, or in those receiving anticholinergics (including antiparkinsonism agents), the special precautions listed in the Prescribing Information should be carefully observed. The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

g hypomanic and manic episodes)
ich may require dosage reduction
d/or addition of a tranquilizer or
mporary discontinuation of the drug,
ileptiform seizures, orthostatic
potension and substantial blood
essure fall in hypertensive patients,
rpura, transient jaundice, bone mar-
w depression including agranulocy-
sis, sensitization and skin rash
cluding photosensitization, eosino-
ilia, and mild withdrawal symptoms
sudden discontinuation after pro-
nged treatment with high doses.
casional hormonal effects (im-
tence, decreased libido, and estro-
nic effects) may be observed.
ropine-like effects may be more
nounced (e.g. paralytic ileus) in
sceptible patients and in those
ng anticholinergic agents (includ-
antiparkinsonism drugs).
tpatient Adult Dosage: Initially,
mg. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)46-850-C
For complete details, please refer to the full Prescribing Information.

Tofrānil® imipramine hydrochloride
Geigy

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Division of Geigy Chemical Corporation
Ardsley, New York 10502

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Another safe long term higher yield investment **5%** (PER ANNUM)

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If hypothyroidism leaves your patient feeling like this...

consider

LETTER®

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Synthetic Thyroid Replacement Therapy



Letter® provides all the advantages of the synthetically pure chemical sodium levothyroxine. Dosage is precise and potency is consistently uniform.

and

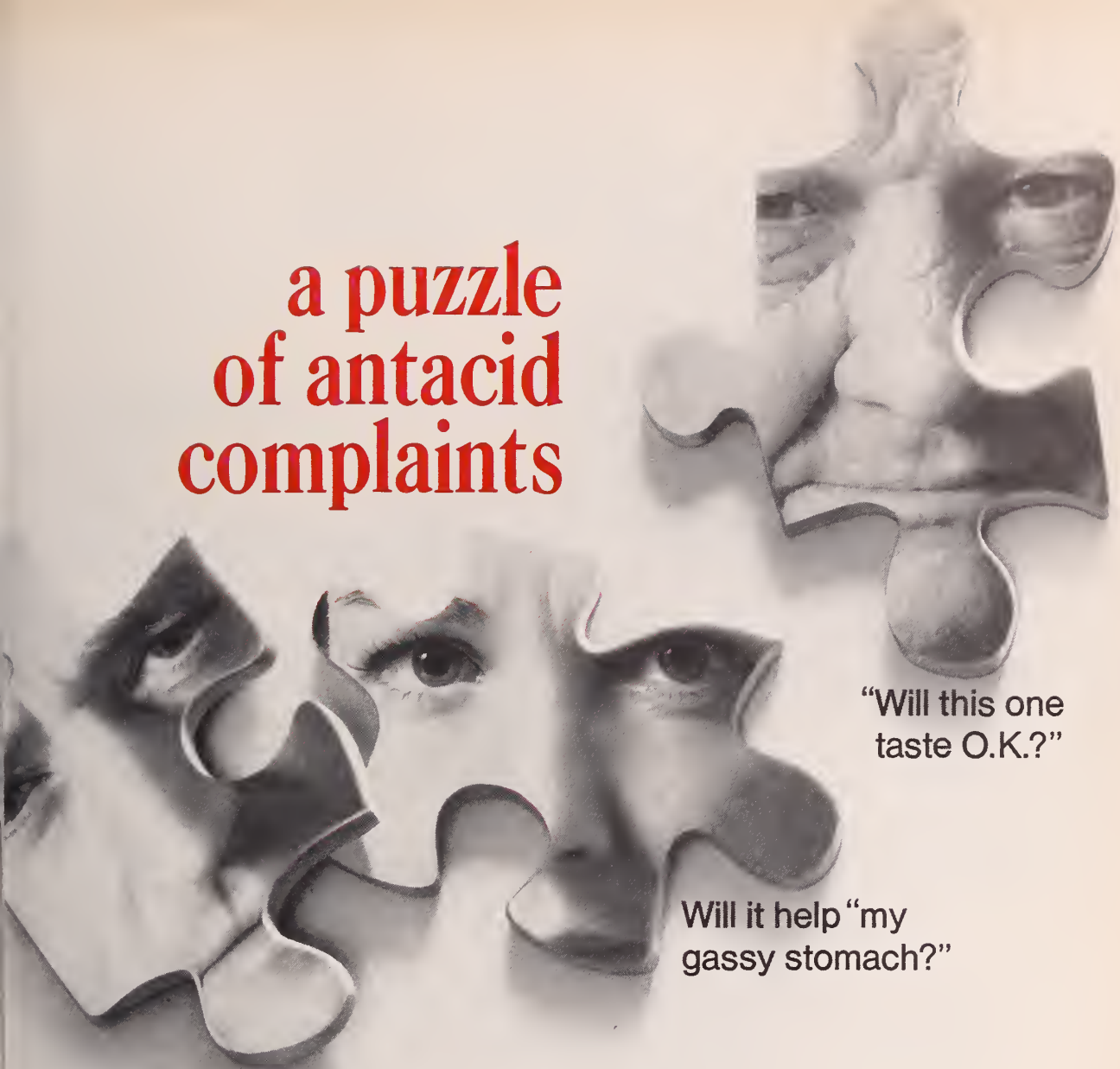
Letter® is micronized to provide maximum opportunity for full absorption and clinical response.

In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

ARMOUR PHARMACEUTICAL COMPANY • CHICAGO, ILLINOIS

a puzzle of antacid complaints



"Will this one taste O.K.?"

Will it help "my gassy stomach?"

"Will it stop the pain?"

Mylanta®

aluminum and magnesium hydroxide *plus* simethicone

a solution to peptic ulcer distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg.
Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

Stuart

Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

new evidence for TAO® (triacetyl-oleandomycin)

a macrolide antibiotic for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital.

*Staphylococcus aureus

study I[1]

Results of a 1967 **in vitro—in vivo** correlation study involving 116 patients with Gram-positive coccal infections in five institutions. All patients were given TAO prior to determining the susceptibility of the offending organism.

97.0%
of the organisms were susceptible to oleandomycin*

98.0%
of the patients responded favorably to TAO® (triacetyloleandomycin)

*In some cases more than one pathogenic organism was isolated from the patient.

study II[2]

Effect of oral therapy with TAO, erythromycin, and cloxacillin on the survival time of Rhesus monkeys after intravenous inoculations of lethal doses of staphylococci, phage type 80/81. (8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that

TAO® (triacetyl-oleandomycin)

was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

TAO Rx Information

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **CONTRAINDICATIONS AND PRECAUTIONS:** Not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including darkfield examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

References: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to Antibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carlisle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. I. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. Soc. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

ROERIG
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235 EAST 42nd STREET
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For your impatient cold patients

Two sprays from NTZ Nasal Spray—and nasal congestion, rhinorrhea, sneezing are reduced for *immediate* comfort for patients with colds.

NTZ is more than a simple vasoconstrictor. It contains:

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction on contact.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.

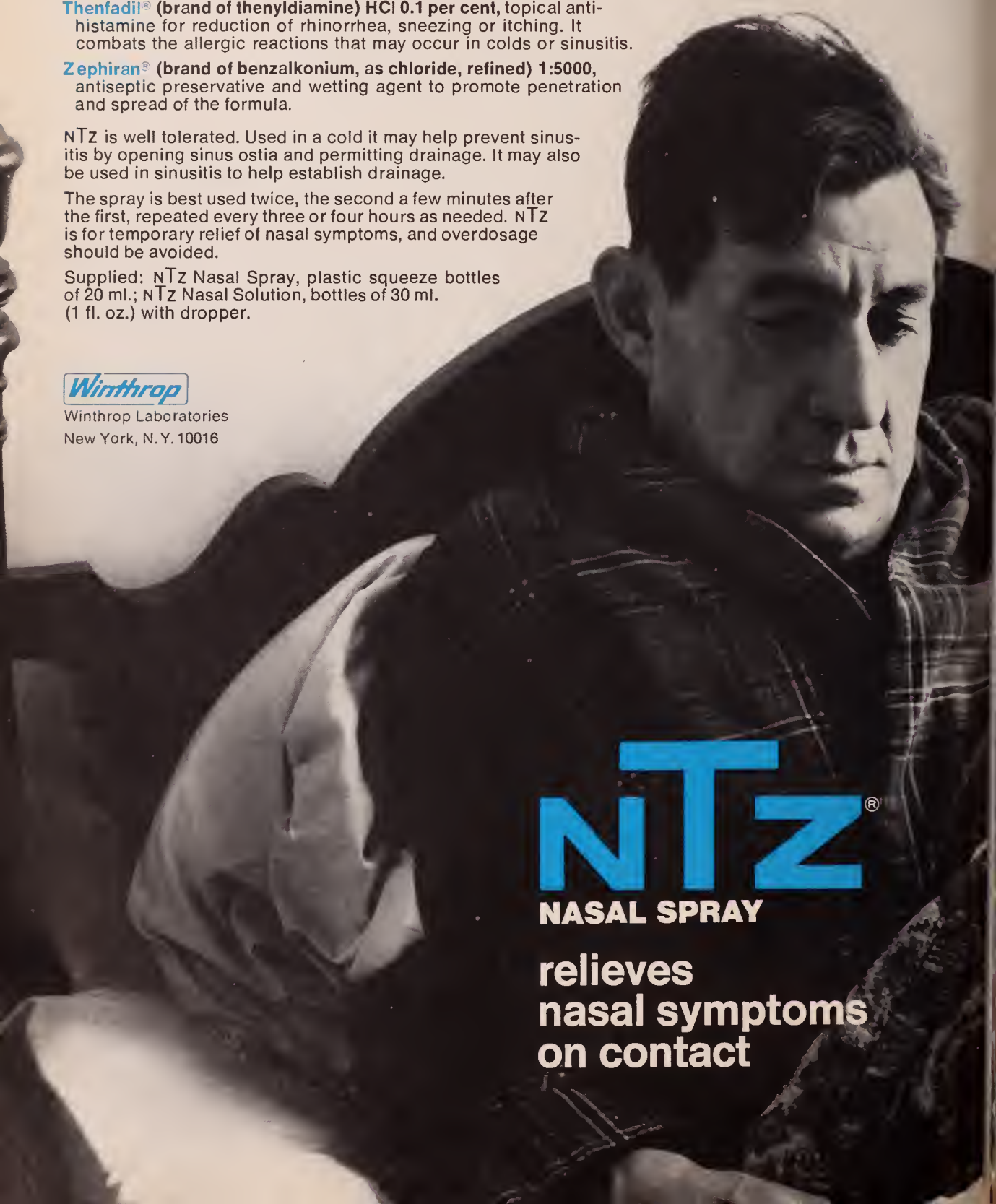
NTZ is well tolerated. Used in a cold it may help prevent sinusitis by opening sinus ostia and permitting drainage. It may also be used in sinusitis to help establish drainage.

The spray is best used twice, the second a few minutes after the first, repeated every three or four hours as needed. NTZ is for temporary relief of nasal symptoms, and overdosage should be avoided.

Supplied: NTZ Nasal Spray, plastic squeeze bottles of 20 ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

Winthrop

Winthrop Laboratories
New York, N.Y. 10016



NTZ®
NASAL SPRAY

relieves
nasal symptoms
on contact

IMPORTANT FACTS

about

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A tablet-a-day provides:

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Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

* anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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A Division of American Cyanamid Company
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FOR SALE—In New Jersey. Two story frame building. First floor 7 rooms, modernized physician's office established in 1938. Second floor LARGE 3½ room apartment. 40 minutes from New York City. Accredited hospitals, Rutgers Medical School nearby. Write Box No. 70, c/o THE JOURNAL.

OFFICE SPACE FOR RENT—Madison, 20 miles from New York City. New 12,000 square foot, fully air-conditioned Medical-Dental complex with 150 parking spaces, x-ray, laboratory, rehabilitation facilities. Richard A. Raffman, M.D., F.A.C.S., 68 Green Avenue, Madison, New Jersey 07940. Telephone (201) 377-8076.

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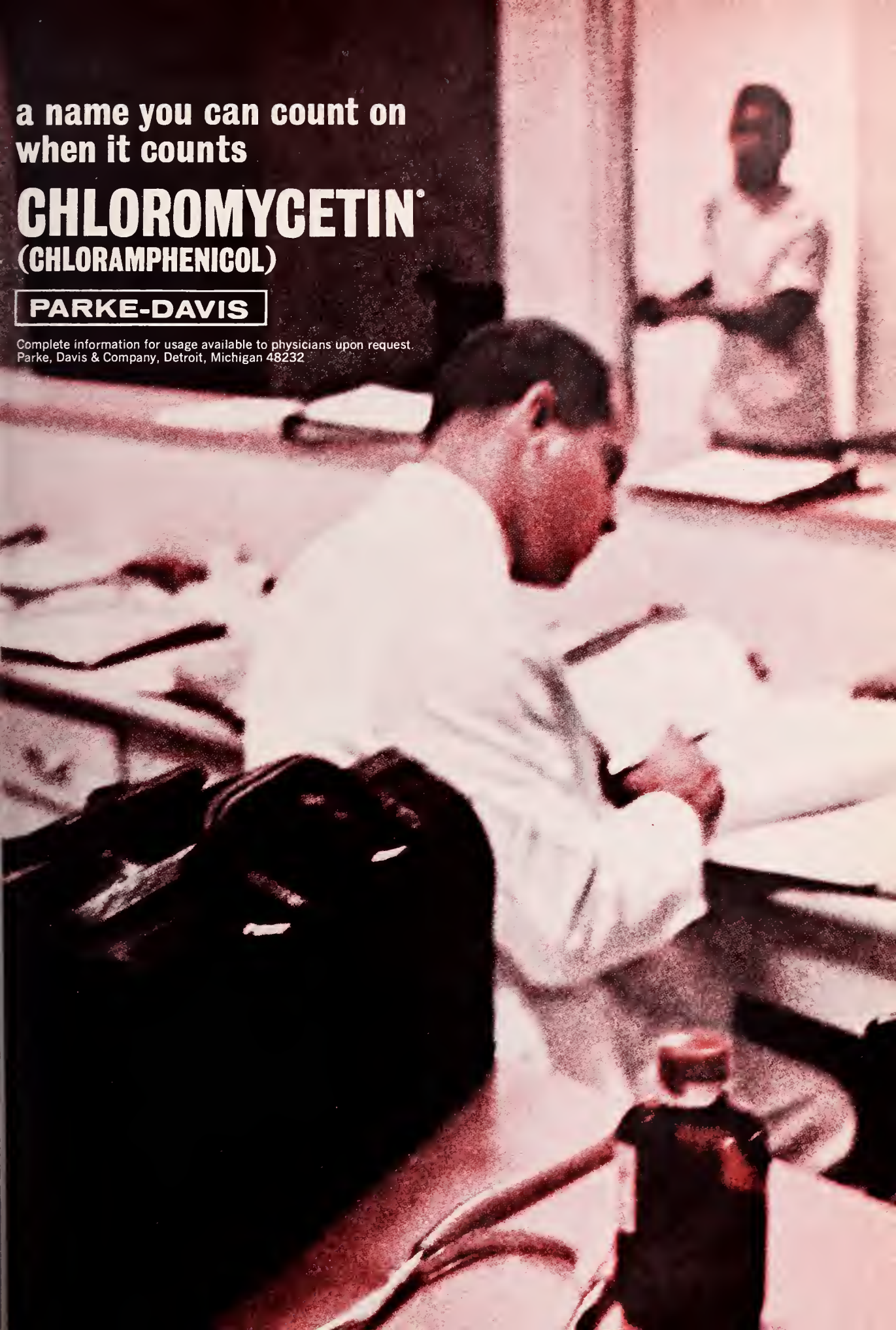
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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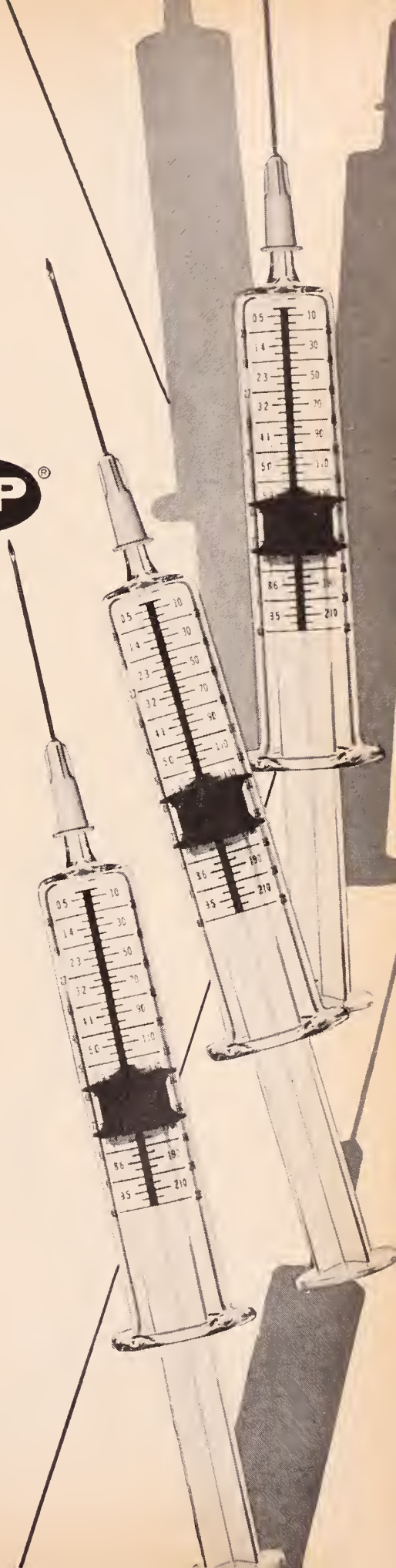
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THE JOURNAL is published monthly (since 1904) by The Medical Society of New Jersey — under the direction of the Publication Committee — 315 West State Street, Trenton, New Jersey. Phone: 394-3154 (Area Code 609); Printed and Published at Periodical Press, 3rd and Hunting Park Avenues, Philadelphia, Pennsylvania.

SUBSCRIPTION RATES — Price per year in advance, including postage: United States, $5. Foreign, $5, plus postage.

SINGLE COPIES—50 cents each. If more than two years old, $1 each.

Second-class postage paid at Philadelphia. Address all communications for publication to P. O. Box 904, Trenton, New Jersey 08605.

EACH MEMBER of the Society is entitled to receive a copy of THE JOURNAL every month. Whole number of issues 762.

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Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

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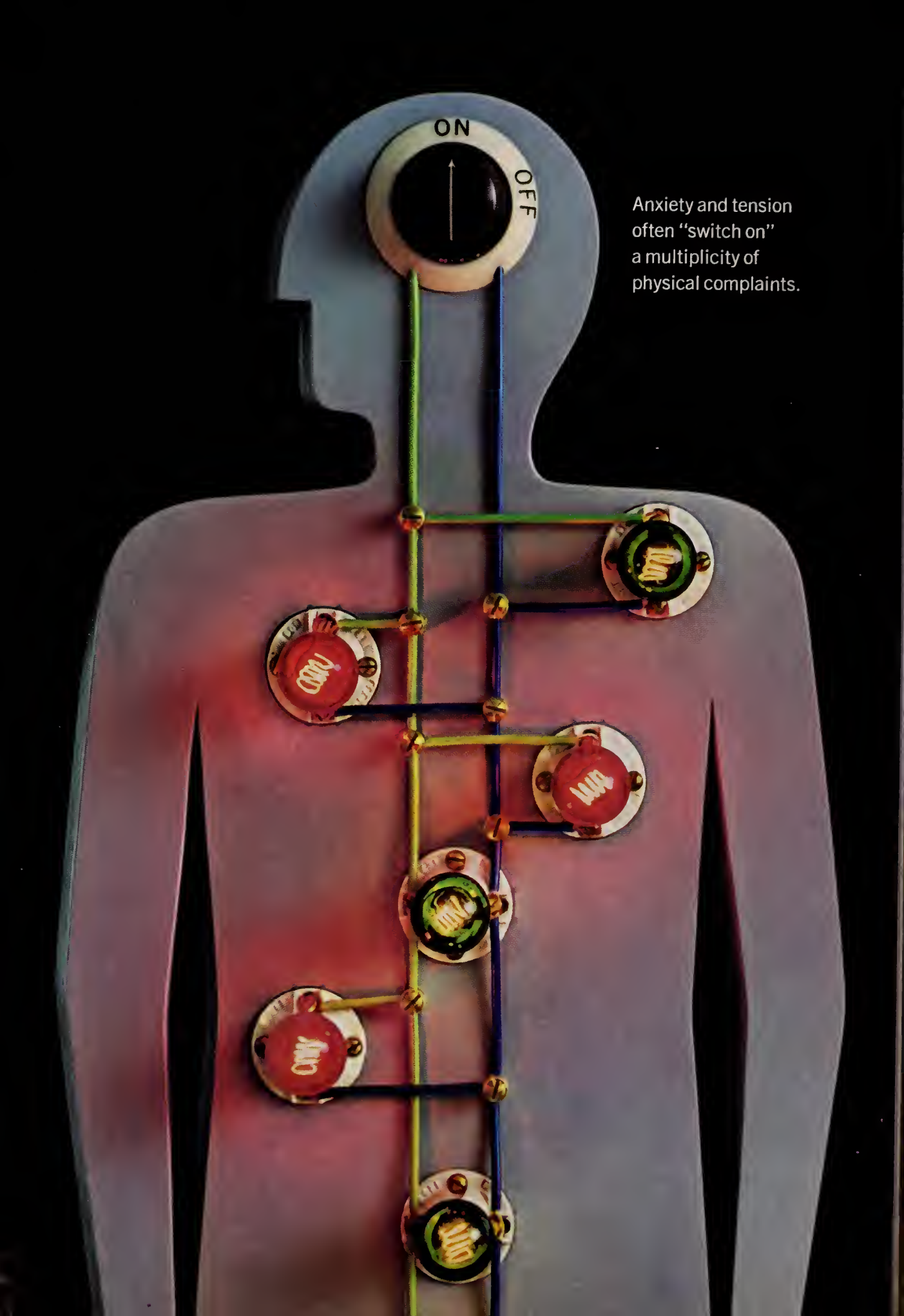
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Contraindications. Tybatran (tybamate) should not be administered to patients known to be hypersensitive to the drug. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings. Simultaneous administration to psychotic patients of tybamate with phenothiazines and other central nervous system depressants has in a few instances been associated with the occurrence of grand mal or petit mal seizures. Seizures have been reported with administration of phenothiazines alone, but not with administration of tybamate alone; nevertheless, tybamate should be used cautiously in individuals who are receiving other central nervous system depressants or have a history of convulsive seizures. Also, it should be borne in mind that simultaneous administration of tybamate with alcohol or with other psychotropic agents, particularly phenothiazines or monoamine oxidase inhibitors, which are known to potentiate the action of other drugs, may result in additive actions.

Precautions. There has been no evidence to date of the development of habituation or addiction. Investigators have not observed excessive self-medication or any withdrawal symptoms with use of Tybatran (tybamate), but the latter should be kept in mind with cessation of the drug after prolonged use. Because of the occurrence of

Prescribing information continued on next page.

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withdrawal symptoms or exacerbation of presenting symptoms upon rapid withdrawal of other agents of this type, abrupt withdrawal of Tybatran (tybamate) should be avoided. Tybamate, like other psychotherapeutic agents, should be used with caution in addiction-prone individuals. Should symptoms of hypersensitivity occur, administration should be discontinued at once and appropriate symptomatic treatment initiated. Operation of motor vehicles or machinery or other activities requiring optimal mental alertness should be avoided if drowsiness or vertigo is present. As with any new drug, Tybatran (tybamate), should be used with caution in patients with a history of drug allergies, blood dyscrasias, and hepatic or renal disease; and prolonged and/or high doses of tybamate should be accompanied by periodic measurements of hepatic, hematopoietic, and renal function.

Adverse reactions. While these have only rarely required discontinuation of the drug, the most frequently encountered reactions have included drowsiness, dizziness, nausea, insomnia, euphoria. The drug was discontinued in one child because of a possible drug-induced urticaria, and skin rash and pruritus have been encountered in a few other patients. In a few patients, effects suggesting excessive stimulation such as hyperactivity, fidgetiness, flushing, and tachycardia have been encountered. Other reported side effects recorded only a few times to date have included ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients to whom tybamate (up to 6000 mg. daily), phenothiazines, and other psychotropic agents were administered simultaneously. Convulsive seizures have not been reported with the use of tybamate alone.

Until clinical experience has accumulated with this drug, inasmuch as tybamate is related to meprobamate, the physician should be cautious about the possibility of rare, serious adverse reactions such as may be encountered with the latter drug. Should excessive doses of tybamate be ingested, it is recommended that any drug remaining in the stomach be removed and symptomatic therapy, including central stimulants, be used as necessary.

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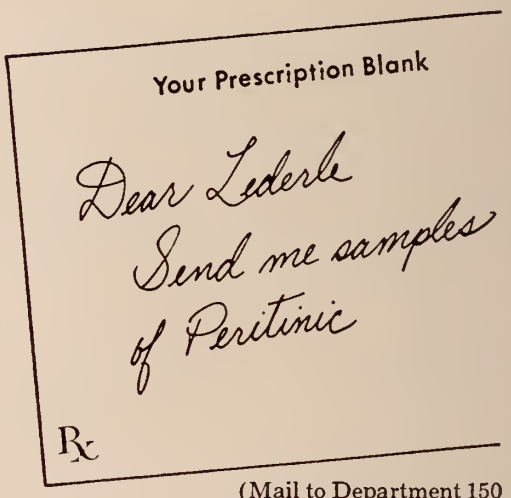
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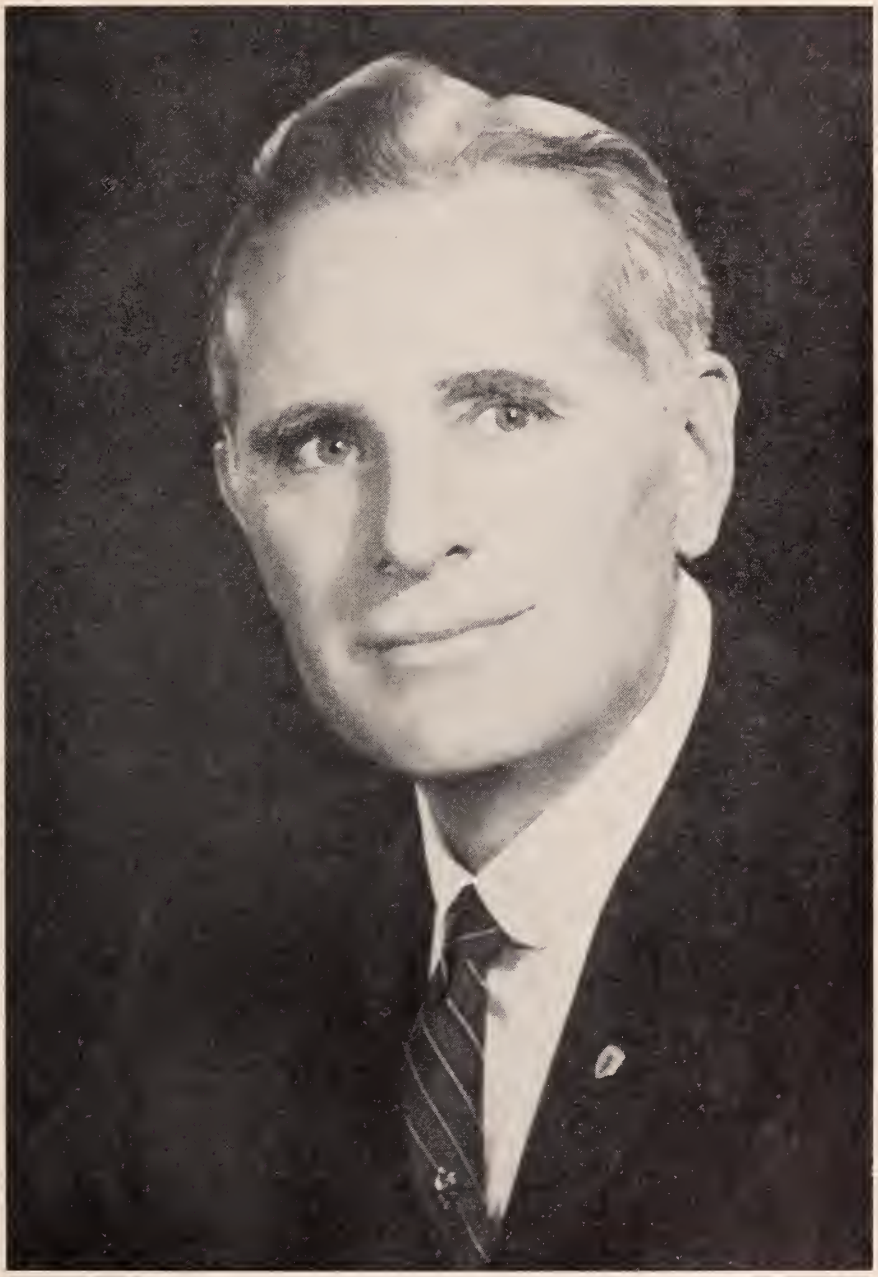
● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

Lederle

489-7—6063

In Memoriam



Nicholas F. Alfano, M.D.

July 14, 1910 — January 4, 1968

President, Medical-Surgical Plan of New Jersey

BLUE SHIELD
MEDICAL-SURGICAL PLAN ®
OF NEW JERSEY
(New Jersey Blue Shield Plan)
500 Broad Street, Newark



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria, serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. & mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weigh (increase or decrease), changes in cervical erosion and cervical secretion suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, change in libido, changes in appetite, cystitis like syndrome, headache, nervousnes dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodo sum, hemorrhagic eruption, itching

The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has been neither established nor disproved): thrombophlebitis, pulmona embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine an decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF

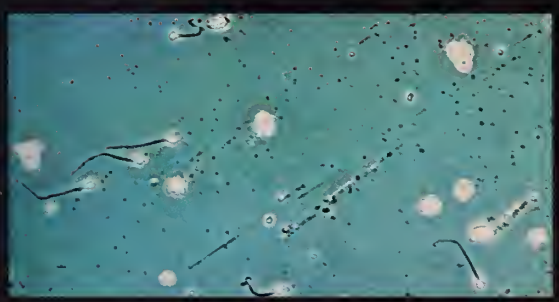
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

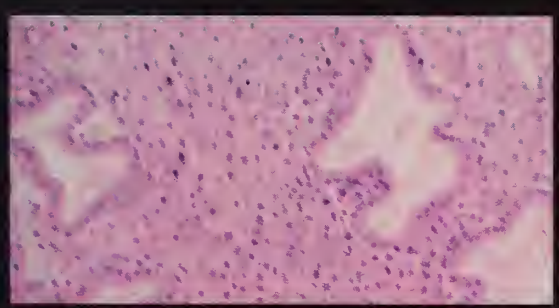
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

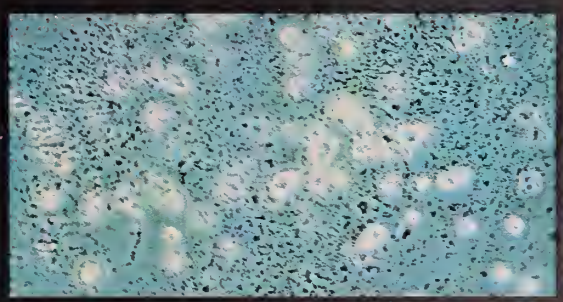


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

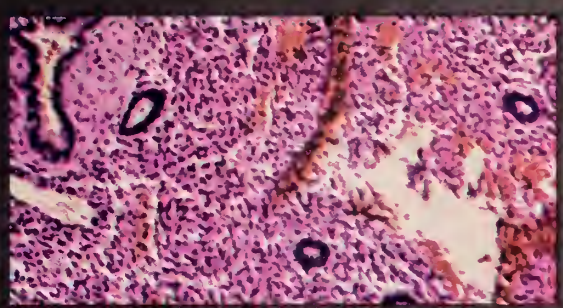
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1
(norethindrone 1mg ĉ mestranol 0.05mg) tablets

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the "economy" of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar®
fluocinolone acetonide





For everyday topical steroid therapy

Synalar® 0.01%

fluocinolone acetonide provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

fluocinolone acetonide—an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.





"Yes, Doctor, the pain is gone."

EMPIRIN'® COMPOUND with CODEINE PHOSPHATE gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.


on call...
Keflin®
Sodium
Cephalothin
KEFLIN®
SODIUM
CEPHALOTHIN
4 Gm.
AMPOULE No. 738
Lilly
Eli Lilly and Company
Indianapolis, Indiana 46206



Fatty, that's what the other kids call Joel. And like many pudgy youngsters, he hides inside what he's afraid to show on the outside.

His mother doesn't realize that his baby fat is fast becoming obesity.

Now is the time to help.

Now is the time for you, as a professional, to educate his mother. Explain the importance of a balanced diet — meat, breads and cereals, fruits and vegetables and dairy foods. Stress proper rest and exercise.

Project Weight Watch can help, too. Our free portfolio includes professionally prepared materials to help mothers learn about children's diets. Send for them today.

PROJECT WEIGHT WATCH
FACTS, NOT FADS

If Fatty loses, Joel wins.

Name

Position

Address

City State Zip

Dairy Council of Northern New Jersey, Inc.
100 Halsted Street
East Orange, New Jersey 07018



Tandearil®, oxyphenbutazone, 100 mg. tablets

Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis, severe forms of a variety of local inflammatory conditions. (In inflammatory conditions not involving prolonged or fatal disease, use only when severity of condition balances potential toxicity.) The drug has no significant uricosuric action but is of value only in the treatment of acute gouty arthritis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy, history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: Tandearil is an analog of phenylbutazone, sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by with-

"Pain Break" for an osteoarthritic. Tandearil can ease it.

At 46, her knees still look good on the outside. But inside, there may be the familiar picture of osteoarthritis.



If aspirin doesn't help, Tandearil often will. Pain and stiffness begin to ease up in 3 or 4 days. You can often maintain response with a daily dose of only 1 or 2 tablets.

Of course, Tandearil is not for every osteoarthritic. Select your patients carefully and follow them in line with the Contraindications, Precautions, Warning, and Adverse Reactions listed below.

But for many aspirin-stubborn osteoarthritics, let Tandearil ease the unwelcome pain breaks of osteoarthritis.

Tandearil®
oxyphenbutazone

olding dietary salt, reduction in dosage or use f diuretics. In elderly patients and in those vith hypertension the drug should be discon- nued with the appearance of edema. The rug has been associated with peptic ulcer nd may reactivate a latent peptic ulcer. The atient should be instructed to take doses im- ediately after meals or with milk to minimize astric upset. Mild drug rashes frequently ubside with reduction of dosage. However, ash accompanied by fever or other systemic eactions usually requires withholding medica- on. Purpuric rash has also been reported. granulocytosis or a generalized allergic reac- on similar to a serum sickness syndrome may ccur and require permanent withdrawal of edication. Stomatitis, salivary gland enlarge- ent, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. It is usually unnecessary to exceed 4 tablets daily. A trial period of 1 week is adequate to determine response; in the absence of a favorable response, discontinue. Maintenance: An effective level is often achieved with 1 or 2 tablets daily, do not exceed 4 daily. 6562-VI(B)R2

For complete details, please see full prescribing information.

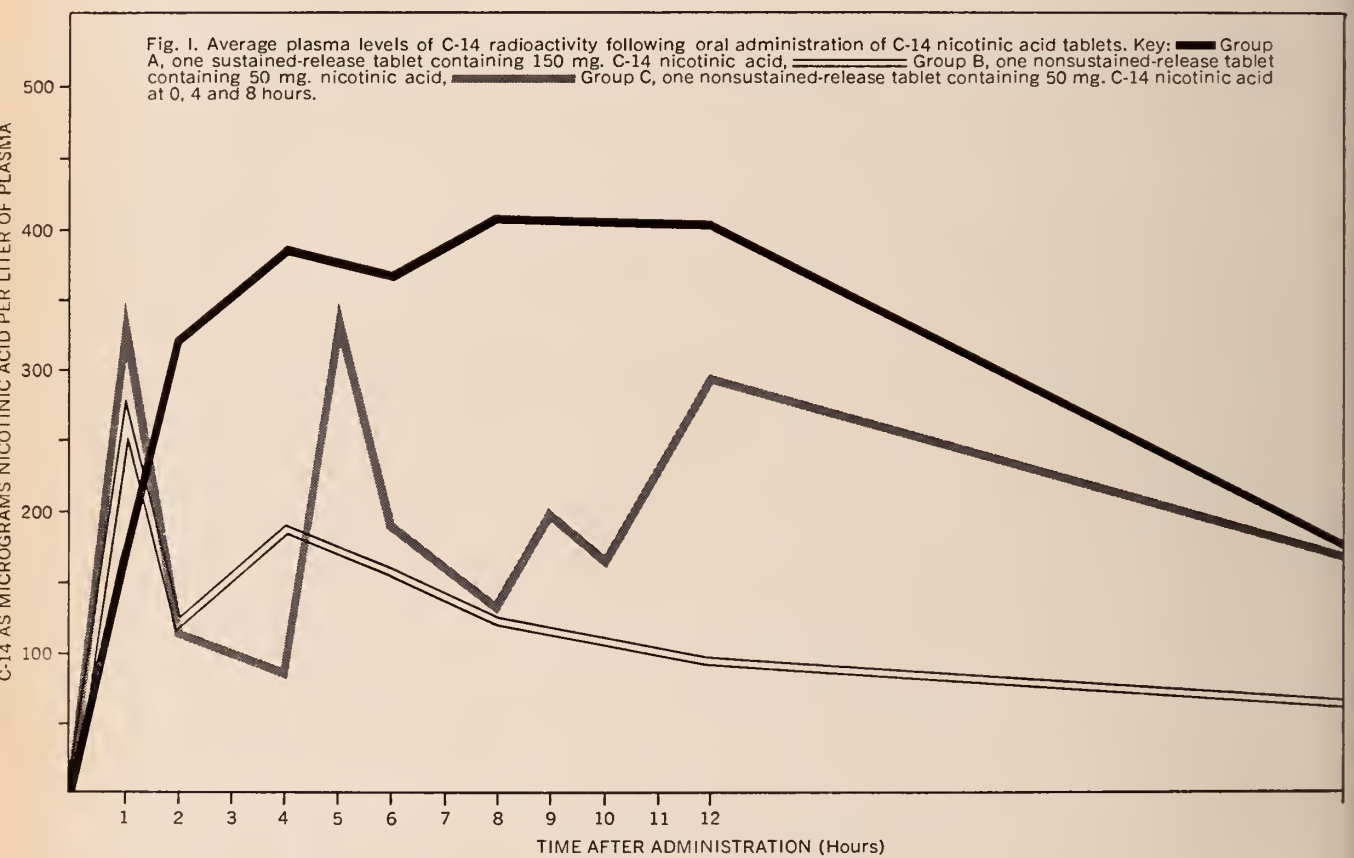
Geigy

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

TA-5806

Sustained circulatory, respirator
and cerebral stimulation for th

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

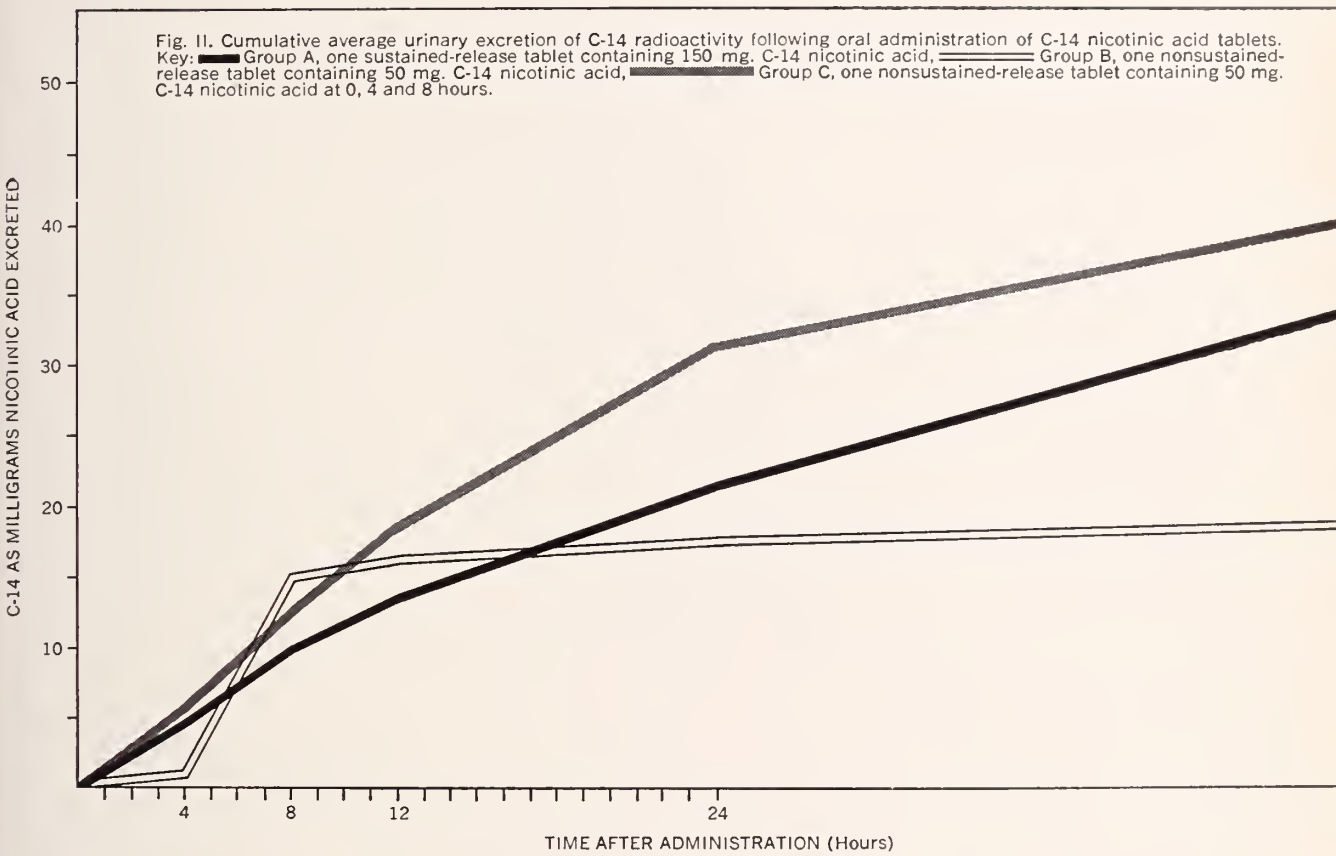
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

aged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet



when he just can't sleep

Tuinal

One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in ¾, 1½, and 3-grain Pulvules



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

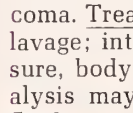
Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206

Lilly

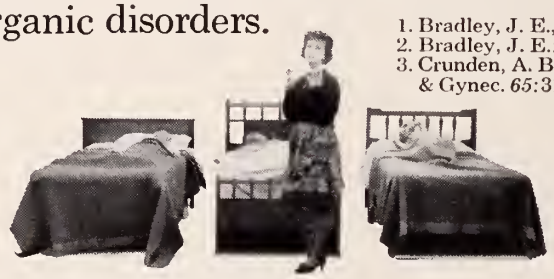
802865



Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity[1] or side effects[2,3] and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. *38*:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. *20*:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



ROHER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate solution
emesis control

Easy on the Budget...
Easy on the Mother

Tablets & Elixir
For Iron Deficiency Anemia

FAMOUS **Fergon®**
brand of FERROUS GLUCONATE

BREON

BREON LABORATORIES INC.
Subsidiary of Sterling Drug Inc.
90 Park Avenue, New York, N.Y. 10016

DORSEY "FLU-GRAM"

DON'T BE LULLED BY RELATIVE LACK OF FLU LAST WINTER. THIS WINTER BE PREPARED: WHEN THE COMPLAINTS ARE COUGH AND CONGESTION, YOU CAN RELIEVE THESE SYMPTOMS WITH TUSSAGESIC TABLETS. ONE TIMED-RELEASE TABLET AT MORNING, MIDAFTERNOON AND BEDTIME BRINGS UP TO 24 HOURS' RELIEF FROM TROUBLESOME COUGH AND STUFFED AND RUNNY NOSE. TUSSAGESIC IS THE FAMOUS TRIAMINIC FORMULA, PLUS THREE OTHER PROVED CONSTITUENTS. MAKES PATIENTS MORE COMFORTABLE. FAST. ASK YOUR DORSEY REPRESENTATIVE FOR SUPPLY OF STARTER SAMPLES, OR IF FLU IS ALREADY EPIDEMIC, PHONE COLLECT. SEE BELOW.

each

Tussagesic®

timed-release tablet contains:

Triaminic® (phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	50 mg.
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES
a division of the Wander Company
Lincoln, Nebraska 68501

clip and file under "flu"

For relief of "flu-like" symptoms
Tussagesic timed-release tablets

PHONE COLLECT

For emergency starter samples
to Keith Sehnert, M.D.
Medical Director
(402) 434-6311

Fast delivery by your Dorsey Representative

The Mediatric® Age:

Many patients, with or without a functional illness, show symptoms of an aging metabolism: disinterest…lassitude…vague aches and pains.

Mediatric® can help them lead a more active, useful life.



Candidates for Mediatric

Commonly heard complaints from your geriatric patients may indicate an underlying disorder that may require immediate attention—and definitive therapy. But, with or without an underlying functional illness, the patients' physical and emotional well-being may be enhanced by adjunctive steroid-nutritional therapy. That's why so many patients just like these are suitable candidates for MEDIATRIC from their very first visit.

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McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

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about

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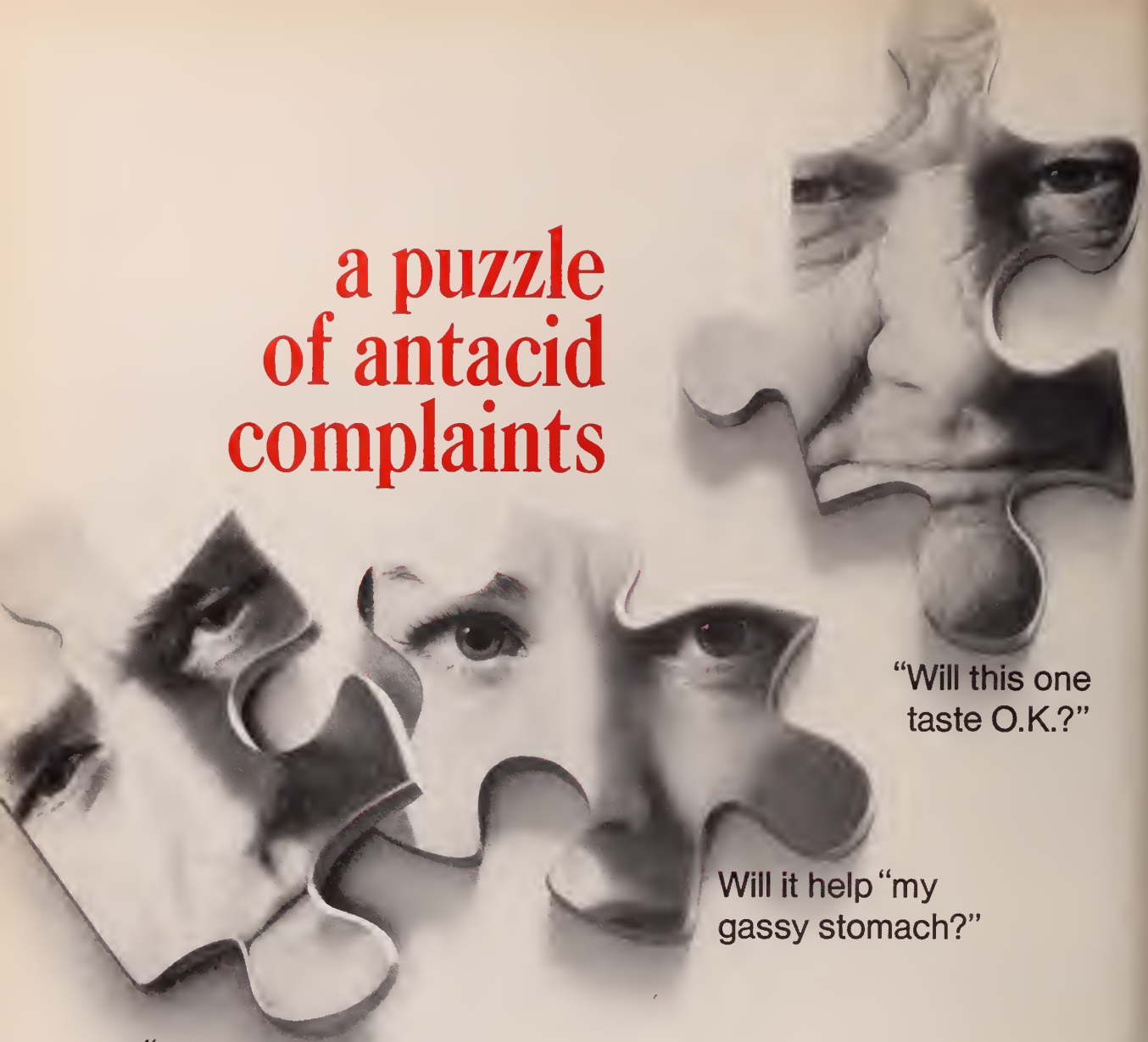
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References: 1. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I.E., Personal communication.

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mportant Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

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Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

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EDITORIALS

Nicholas F. Alfano, M.D. 1910-1968

Elsewhere in this issue we publish a formal obituary on Nicholas F. Alfano, M.D. It would not be fitting however, to let it go at that. Dr. Alfano's passing merits some editorial comment, too. This is, to begin with, the traditional American success story — a physician who started his career quietly with no great pretensions and who ended his career as the president of one of the major physician-sponsored health insurance plans in the country. He was indeed, internationally known in this field. He was one of the small group of leaders who made up the Board of Directors of the National Association of Blue Shield Plans. He was, in his own felicitous phrase, "serving humanity without writing a prescription or making an incision." It was generally agreed that it was to Dr. Alfano's skill and drive that New Jersey Blue Shield owed much of its spectacular rise from two million to three million subscribers, making it one of the largest Plans in the country. He was a superb administrator without ever losing the doctor's touch. He had a difficult role, juggling relations with big business, with subscribers, with labor unions, and with his medical brethren, and he did this with consummate skill. One of the problems faced by our profession is that most physicians are uncomfortable in the managerial and administrative functions called for by this work. Yet, if we did not have men like Nick Alfano, we would have had to abandon the field to laymen, and have acknowledged, in doing so, that we doctors just don't have the administrative talent that is needed. Administration is, after all, getting jobs done through men — and there is no reason we can't provide administrators as effective as those who come out of business colleges and law schools. Nick Alfano had — or discovered, or developed — a talent for doing so. Dr. Thomas J. White, president of the Board of Blue Shield commented that "the entire Blue Shield movement owes much to the unflagging devotion with which he served it." Indeed, we are all in his debt for demonstrating that a physician can combine in himself the skills of the administrator, the dedication of the scientist, and the compassion of the humanitarian, which perhaps should be his epitaph.

Twilight Of The Waiting Room

Some years ago, Jim Bryan* suggested that the doctor never refer to his reception room as a "waiting room" and that he never allow any one else to use that term.

We think that the author is right. After all, a "waiting room" suggests something passive: the patient waits; he sits; he is forgotten. It conjures images of cold, poorly lighted, rural railway stations. By contrast, a reception room suggests something active. Here something is done to and for the patient. He is received. To put it another way, he is welcomed. The phrase "reception room" has an aura of elegance about it.

Since the "appointment" practice (for GPs as well as specialists) has become widespread, there is less use for this room anyway. When it must remain, it could approximate the living room where your guest waits while your wife puts on those last and mysterious finishing touches. Maybe if we all thought of these spaces as "reception rooms," we'd begin to look at them with more critical eyes. The light, the heat, the decor, the reading matter, the spaciousness, the friendly arrangement of chairs—all this goes into good "reception." Whether as an actual room or only as a word, the "waiting room" could well be retired from active duty. Let patients no longer just wait. By all means let them be received. Maybe we ought to go the whole way and call it a "welcome room."

* Bryan, James E.: *Public Relations in Medical Practice*, Baltimore, 1955, Williams & Wilkins.

Illness The Leveller

The president of the company and his janitor are on the same plane when each lies on his chest, his buttocks in the air, awaiting the proctoscope. When a woman is swallowing a stomach tube or receiving a colposcope, then, truly, Judy O'Grady and the Colonel's lady are sisters under the skin.

Illness is a leveller not only because—with their pants down—all men are equal, but also because fear wipes out arrogance and crumbles dignity. Faced with fear of pain, fear of death, fear of disability, all men react according to their temperament and not according to their social caste or income tax.

So it is—or so it should be—that physicians make the best apostles of democracy and the poorest supporters of a "master race" thesis or a "class dictatorship." For, as every physician knows, there are no commissioned officers in the ranks of the frightened, the pained, the crippled, or even in the ranks of the undressed. In that army we are all brethren and sistern.

A Charter For Grandparents

New Jersey was the birthplace of the American Geriatrics Society. It was founded at Atlantic City in June 1942. The idea, of course, is old. The very word, *geriatrics,* was dreamed up by Ignatz Nascher as far back as 1909. The word was constructed on the model of *pediatrics;* physician of the aged, physician of the child.

In the days of Cicero, life expectancy at birth was only 22 years. Today, the figure is 70. There was little use for geriatrics a century ago. There is great need for it today.

As a science, geriatrics is one of the youngest of the medical disciplines. This has given it the advantage of being born into a medical world which puts stress on integration, on total treatment of people rather than partial treatment of organs. So from the beginning, geriatrics has encompassed not only the treatment of diseases of the senium, but also such matters as rehabilitation, social aspects of aging, psychological problems associated with seniority, and so on.

A geriatrician must be a general practitioner. In one day he may have to concern himself with an enlarged prostate, a senile psychosis, a decompensated heart, a severe pruritus, a cataract, a fractured hip, and a diabetes. Just as the pediatrician is the family doctor to the child, so the geriatrician is the family doctor to the aged. Geriatrics is not so much a specialty as an integration of specialties. Without a family doctor or general practitioner to captain the team, the corps of specialists would have the senior citizen fragmented into as many parts as his years.

One of the by-paths of geriatrics is its preventive aspects. But to prevent certain diseases of the old, means to do something for people in middle life. So the geriatrician must reach back into earlier life. In this respect, he must be bolder than the pediatrician who has set a cut-off date for himself.

The child welfare movement, the child-centered home, and doting attitudes of parents toward their children have given to American boys and girls the happiest childhoods in the world. Neglect is one of the hardest indictments that can be returned against an American parent.

Let us not, however, fall into the reciprocal sin. Let us not be guilty of neglect of parents. Companionship, affection, comfort, and a sense of usefulness are the desiderata of old age. When the grown sons and daughters fail to provide their parents with those things, they are as guilty of neglect as if they had starved them. The children's charter is a precious document in the American heritage. It is time for some one to write a charter for grandparents. And these same words may well be engraved on that charter: companionship, affection, comfort, and a sense of usefulness. Small rewards for a life-time of service!

ORIGINAL ARTICLES

Perhaps organized medicine is facing stormy weather. And in stormy weather it is best to be on the inside looking out, not vice versa.

You Are Your County Medical Society

Irving Chrisman, M.D./Paterson*

I was born and raised in Paterson, attended public schools in this city, and returned from medical school to practice in my home community. Thus, to be installed as President of this 124-year-old organization is a deeply moving experience for me.

In this brief talk, I will suggest some of the changes which have taken place in the activities of the county medical society, and some elements of continuity which persist essentially unchanged through the years. I would then hope to relate this change and continuity to the basic concerns of this presentation: the relationship of the county medical society to its members, to the community and to the practice of medicine.

It has been wisely remarked that those who ignore history are destined to repeat it. Ignorance of the past will expose us to the pitfalls and errors of our predecessors. If we look at the history of county medical societies, we perceive a continuing concern with a basic problem which persists today: organization and participation. The methods used to cope with the problem may have changed, but the problem remains.

The bylaws of the first county medical society in New Jersey (Somerset, 1816) provide that a fine of $20 be imposed on a member absent for several consecutive sessions, or failing to discharge a duty assigned to him. Think of the treasury our Passaic County Medical Society would boast today if we had, early in our existence, enforced such a regulation. The Morris County Medical Society once levied a fine of $20 on members failing to attend a meeting; and then used the funds to pay for the dinners of the faithful physicians who did attend. And despite this negative and positive stimulation, the Morris County Society couldn't produce a quorum in 1857, and meetings had to be suspended until a reorganization took place in 1873. And many of us think we are too busy to attend the meetings of our County Society!

What was the focus of interest at some of these early meetings? I quote briefly from *The Healing Art*:[1]

"The members (of the Monmouth Society) met to exchange experiences and share medical publications. The Society subscribed to two periodicals. These, with the medical books the members shared, necessitated the purchase, in 1832, of a bookcase.

"Temperance-minded Monmouth doctors adopted a resolution in 1834, and had it printed in local newspapers declaring, 'ardent spirits (alcohol) are not needed in health; on the contrary, it is not merely useless, but pernicious, productive of disease and death.' Twenty years later, in keeping with his philosophy, the members resolved that no more wine bills should be paid from Society funds. After some debate, the use of cigars was allowed to continue at Society expense.

"Somerset Medical Society meetings were not all business. One itemized bill included charges for twelve dinners at five shillings each, plus one glass of cider, four glasses of wine bitters, one glass of brandy, two of rum, 28 Spanish cigars, and hay and oats for 11 horses.

* Address by Dr. Chrisman as the incoming President of the Passaic County Medical Society, October 18, 1967.

[1] *The Healing Art*, by Fred B. Rogers, M.D. and A. R. Sayre, is the bicentennial history of The Medical Society of New Jersey, published by the Society in 1966.

"Members were appointed for each half-year session to report their meteorological observations and the prevailing diseases in the county in the past six months."

Compare, if you will, the scientific and socio-economic concerns of these bygone days with the concerns of a county medical society (our own in this case), as indicated by a partial recounting of the agenda of a recent meeting. Consider just these three items as an indication of the changed world in which we live: Progress of the Passaic Valley Health Facilities Planning Council; Progress of the Passaic Valley Community Blood Program: Progress of Community Mental Health Facilities in Passaic County. Can one be blamed if he occasionally longs for what are called, probably erroneously, the "good old days."

What seems to be happening, and I fear too few of us may be facing up to the reality of it, is that American medicine is being placed increasingly in a position where we must put up or shut up. Without sacrificing our ethics, our standards, and our independence, we must yet enter the market place of American life; we must offer our wares, and we must push them with all the vigor of which we are collectively capable — if we are to maintain a voice in present and future medical practice in America. And how is this to be accomplished? In only one way, namely, through the *county medical society!* We are admonished from every side to this course of action. Listen, first, to the new President of the American Medical Association, Dr. Milford O. Rouse, of Dallas.

"The greatest imperative for every physician is to become a participating, responsible citizen within his community. It is only as the members of the *county medical society* carry their share of the load as responsible citizens that their fellow citizens will look to them as advisers in matters of health.

"Where there are any vacuums in health care services, government and social welfare planners are always quick to step in. Unless medicine maintains the leadership, the signals may be called by quarterbacks of markedly different philosophy."

Now listen to a small excerpt from an editorial which appeared in a recent A.M.A. *News*:

"The changing concepts of medical practice affecting the physician, hospital and patient are placing increasing demands upon the M.D. to exercise his influence to protect the quality of care for his patient. State and county medical societies and individual physicians should seek to implement the A.M.A.'s recommendations (to this end) wherever possible."

Now you may say that you have heard this message before, and to some extent, this is true. But at this point, I would like to spell out a basic change which has taken place in the life of the county medical society, as well as the elements of continuity. This change is the vanishing degree of choice left to us, as a county medical society, in America today. We either plunge in vigorously, or we fall by the wayside and become a hollow vestige of what was once the heart of American medicine.

I am not saying that medicine is responsible for the whole waterfront, as it were. I am not the bleeding heart variety of physician who would take all the problems of mankind unto himself. On the contrary, I look at this situation quite coolly. What I am saying is that medicine had better see that it has a hand in the rapidly evolving health care patterns of this country, starting at the county society level. If we decide to "let George do it," we had best see to it that we are working right alongside of George and that, as a member of the medical society of his county, George turns to us for consultation and advice.

With every passing day, this message becomes more vital, more significant to you and to the community. It becomes daily more meaningful to the practice of medicine, and to the health and well being of every American.

Why do I take your time and mine to talk to you so vehemently tonight? Because of what I fear is the terrible misunderstanding revealed by the physician who asks, "What is my county medical society doing for me?" This simple and far too frequently asked question reveals the tragic alienation of many physicians today from their society, their community, and their times. To me, it is somewhat equivalent to a soldier whose regiment is under murderous crossfire, with survival itself in doubt, who in the midst of battle asks his lieutenant, "What is this regiment doing for me?" It is, indeed, like asking, "What am I doing for myself?" Because each and every one of you is the Passaic County Medical Society. And when some of you ask what "It"

is doing for you, I fear that you reveal a tragic shortcoming in American medicine of the past 35 years — the sense of detachment, of alienation, the failure to realize that we could no longer stand by, that we must choose either to participate and help direct evolving national health patterns or be swept aside, an irrelevant factor in a period of irresistible social change.

In conclusion, let me say this: at my behest, our Society will hold two meetings during the coming year at which members will have an opportunity to vent their grievances about the society and related matters. Let the gripers beware that they may come away from these projected meetings, to their surprise, new members of regular or special committees of our county medical society, in whose areas of interest the gripes have been expressed.

I say this seriously, because if there is one basic and overriding goal that I have set for myself for my term as President, it is to convey the vital concept that this Passaic County Medical Society is *our* Society, the local action organization of *our* profession, serving *our* community. All three will be only what *we* help to make of them.

423 Broadway

Frightening The Public About Radiation

Many Americans have been alarmed by the statement of a physicist that "thousands of deaths" are caused annually by radiation exposures from routine diagnostic x-ray examinations. A representative of the American College of Radiology has replied that there is no known instance in which a routine x-ray examination was ever fatal to a patient because of radiation exposure. This was in response to an assertion that 3,500 to 29,000 deaths a year were caused by radiation damage from diagnostic medical exposure. This fear was expressed to a Senate Commerce Committee by K. Z. Morgan, Ph.D. of the Oak Ridge National Laboratory. No other witness before the Senate group, however, supported Dr. Morgan's assertions. On August 31, Dr. Lauriston S. Taylor of Washington, a physicist and president of the National Council on Radiation Protection and Measurements, told the Senate Committee that Dr. Morgan's claims were "based upon pure speculation, without any clinical facts to support them."

A recent nationwide survey by the United States Public Health Services has concluded that *medical x-ray uses account for only half as much exposure as the average American receives annually from natural background sources.* The medical exposure to reproductive organs was estimated at 55 millirems* and the average background exposure of Americans at 120 millirems per year! Background radiation comes from natural radioactivity in the soil, in cosmic rays from the sun, in food, and in body substances. Another radiologist pointed out that the profession cannot accept the kind of generalizations made in this testimony. "Dr. Morgan's omission of the relationship between the natural burden and man-made radiation represents a regretable distortion."

The American College of Radiology points out that the need for diagnostic information by a patient's own physician is the only sound reason for subjecting a patient to an x-ray examination. "We feel a direct responsibility to see that our examinations are done efficiently and safely so that the maximum benefit is attained with the minimum risk to all concerned."

* A millirem is a thousandth of the basic unit of absorbed radiation.

Blessed is the man who is never conscious of the sounds of any of his body organs!

An Unusual Psychiatric Disorder Following Cardiac Surgery

Constant Awareness of the Clicking Noise of a Vascular Prosthesis

Allen Welkind, M.D./Maplewood*

Psychiatric disorders sometimes follow open cardiac surgery.[1,2,3,4] An unusual complication was seen in an eighteen-year old male admitted to the cardiac service of the New Jersey College of Medicine (then Seton Hall) in March, 1964. At nine he had had an attack of rheumatic fever. There was clinical evidence of mitral insufficiency at twelve. Later examination indicated progression of the valvular involvement to mitral stenosis and insufficiency, plus mild aortic stenosis and insufficiency. In 1963 he reported easy fatiguability and palpitation which were caused by atrial fibrillation and congestive heart failure. With digitoxin and quinidine he reverted to regular sinus rhythm. Diagnostic studies, including cardiac catheterization proved the primary valvular damage to be mitral and aortic insufficiency. It was recommended that both these valves be replaced by Starr-Edwards prostheses. He was admitted to the Pollack Hospital in Jersey City. The surgery was done April 8, 1964, under hypothermic anesthesia and the oxygenating bypass. After the mitral valve was replaced the patient's condition deteriorated. It was then decided to do the aortic valve replacement at a second operation.

He did not show any postoperative delirium or hallucinations. During the hospital stay he was irritable, complained of pain and of the restriction of the intravenous needles, catheters, ECG monitors, and the oxygen tent. He was deeply disappointed that the aotric valve had not been replaced.

He began to be aware of the clicking of the valve shortly before discharge but did not mention it until he was home. It was not constant at first but as his strength increased he became more active and the clicking became more noticeable. With it his anxiety rose.

He couldn't sleep and required barbiturates. The noise continued to plague him until he was referred to me in November, 1964. It can be best described by quotations from the four interviews.

"It keeps me awake at night. When I do fall asleep hours later I can sleep for 8 to 12 hours. If I wake at night I can't fall asleep." . . . "It seems louder than it used to be." "As times I can temporarily forget it especially if I'm occupied but if I'm relaxed I hear it most" . . . "If I run up the stairs it is loudest. I hear it when I talk but not when I drive." . . . "The noise distracts me when I read" . . . "It used to be better when I lay on my back, but now I can hear it in any position." . . . "I can't make out with the girl because she hears the valve."

The basic reason for his preoccupation with the noise of the valve is fear of the heart stopping. He is like the patient who has had an attack of cardiac arrhythmia and then listens to his heart to be sure it will continue. The patient who is advised that cardiac surgery is in order reacts with anxiety. This youth, during the four interviews, denied that he had

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any fear of dying during operation. He was amazed that a girl whom he knew, who was operated a few months after he had been, said she was quite afraid, and was delighted to find she had survived when she woke from the anesthesia. In the second interview it became obvious that he was afraid that he was going to die. "I don't trust my heart, I'm afraid it will stop." His insomnia was connected with the need to listen. If he slept he could not be aware of it, which was a kind of loss of control. During the next interview he completely denied it but couldn't explain why he had expressed his fear the week before. The major defense here is denial.

In the few months following discharge his preoperative behavior problems became worse. Drinking sprees led to arrest for drunken driving and loss of his license. He reacted with resentment by further anti-social behavior. At the time of his visits he was under indictment for trying to run down a policeman with a car. He was sentenced to jail for six months. Another time he fell when drunk and sustained a large hematoma which had to be evacuated surgically. He subsequently developed an arteriovenous aneurysm of the scalp which was excised. An electroencephalogram showed a cerebral dysrhythmia indicating a focal lesion. There is no clinical evidence of epilepsy. Since the behavioral difficulties appeared *before* the head injuries, it is not likely that he has been suffering from psychomotor epilepsy.

He has now been found guilty of burglarizing a doctor's office trying to steal barbiturates. He says that he needs this because the valve clicking had been troubling him. My information, of course, is second-hand and may not be accurate. It is unfortunate that he did not continue in psychotherapy. He failed to keep several appointments before his incarceration and made no serious efforts to find treatment afterwards.

One must consider the possibility that his acting-out is counterphobic. His intense anxiety to being tied down by the catheters, electrocardiac monitor wires, oxygen tent, etc., indicate claustrophobic reactions. The years of physical illness in an adolescent with rheumatic heart disease produced resentment at the restriction. He showed anger to his parents who were neither encouraging nor understanding. Allegedly, they told him that he ought to get a job several months after surgery. When he ran into trouble with the law, his mother tried to help at first but no longer does much to help him.

Recently he told Dr. A. B. Weisse of the Cardiac Service that there are times when he no longer noticed the clicking of the valve. I have not been able to investigate and treat him further.

Some workers, I have been told by Dr. Weisse, have encountered this disorder in other patients who were cured of the symptom by hypnosis. My own opinion is that this youth would benefit best by long term psychotherapy.

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638 Prospect Street

A new and fairly simple technic is offered for early identification of masses in the breast.

Mammary Gland Topography

A New Clinical Approach In The Early Diagnosis of Breast Cancer
Preliminary Report

Edward W. Verner, M.D./Newark

Today the breast is the leading site of fatal cancers in women. There will be an estimated 64,000 *new* cases this year with some 27,000 deaths.[1] Indeed, the life-time risk of this disease in a woman is 5.5 per cent.[2] During an anticipated life span of 72 years, *one of every eighteen women will develop cancer of the breast.* The mortality rate of cancer of the breast has remained practically constant for over 30 years, but the gross number of deaths has increased steadily during this century.[3] In 1930 the death toll was 11,000. It was 22,500 in 1958, and is now about 27,000 yearly.[4]

In general it may be stated that the earlier the lesion is discovered, the better the prognosis, notwithstanding the varying degrees of malignancy. It is, of course, true that ideally we need to know exactly when the lesion began in order to offer the best prognosis with our present therapy. However, lacking this information, our alternative is to discover the lesion as early as possible and procede from this point. We are aware of the rather pessimistic viewpoint that early diagnosis and treatment has little influence on the ultimate outcome.[5] However, Haagensen's investigations[6] have shown that from 60 to 70 per cent of small carcinomas of the breast (under 11 millimeters) have not metastasized to the axilla when the disease is discovered. But, over 70 per cent of large carcinomas (80 millimeters and over) have metastasized when the patient comes for treatment.[6]

Up to the present, palpation has been the principle, most basic and practical method of examination by which breast tumors are detected, both by clinician and patient alike. This has been supplemented by recent advances in mammography and thermography. As an extension of palpatory examination of the breast, we would like to introduce mammary gland topography. Mammary gland topography is the digital examination and simultaneous graphic recording of the surface "pattern" of glandular tissue, and the individual characteristics of the surface lobules.

This original study, begun in 1960, was based on the theory that surface anatomic changes in the breast reflect changes taking place in the deeper portions of the gland. The hypothesis was that palpable changes on the breast surface precede the development of a discrete mass or tumor. Accordingly, ways, means, and materials were sought by which the lobular surface anatomy or topography of the breast could be imprinted or moulded. Several materials were investigated. None proved adequate or practical. Finally it was decided that digital palpation with a concomitant graphic recording was the most practical method of making the desired graphic representation. To date, some 1000 topograms have been made.

Each mammary gland is an aggregation of a number of compound alveolar glands. Each consists of fifteen to twenty lobes, subdivided into lobules.[7] The breast consists of glandular tissue, fibrous tissue connecting its lobes and fatty tissue in the intervals between the lobes and lobules. The lobule when freed from fibrous tissue and fat is of a pale reddish color, firm in texture, flattened from before backward and thicker in the center than at the circumference. The gland rests partly on the deep fascia of the pectorales muscles and partly on the muscles of the lateral chest wall. Beneath these structures is the bony chest wall which makes for a relatively hard surface against which the soft breast tissue can be palpated.

Topography is done with the patient lying supine with arms outstretched. The examiner stands to the patient's left side facing cephalad with a drawing board before him. Palpation is performed with the palmar surfaces of the distal phalanges of the index, middle and ring fingers of the left hand (finger tips) and the drawing or interpretation recorded simultaneously with the right hand. In so doing one develops, over a period of time, a sensitivity or *tactus eruditus* in the examining finger tips through a sharpening of the epicritic sensory mechanism. This is in contrast to the conventional methods of breast palpation in which the palmar surfaces of the proximal phalanges and the palm of the hand are used in an attempt to exclude the lobules in search for larger masses. In topographic examination, attempt is made to delineate the surface lobules to determine their individual characteristics and to note the types of patterns they form with the surrounding lobules.

In each breast the following palpatory characteristics of the lobules are graphically made:

1. Presence or absence
2. Size, shape, and consistency
3. Parallelism
4. Coalescence
5. Axillary prolongation

Inasmuch as the mammary glands are mirror images of each other, we expect identical or near identical lobular patterns. Variations (or differences in comparative patterns) indicate trends from the normal toward the pathologic. Hence, in effect, each breast is a "control" against the other. This is of practical importance even in self-examination of the breast, because women are often confused by the generalized "lumpiness" of the surface topography. They should be told that tissue which is palpated at a given site in one breast normally should be felt at the exact same site in the opposite breast; then there would be a baseline for comparison. A recent case is that of a 34 year old female who used this comparative examination to discover a 7 millimeter adenocarcinoma in the left breast.

Normal Patterns

Case 1. A 42 year old married woman. Normal menses.

Figure 1 illustrates a profile of breasts in which the lobules are of equal size and similar shape and consistency. There is an even distribution and equal concentration of lobules in all sectors. The lobules are parallel to each other.

Interpretation: Normal Topogram

Case. 2. 40 year old married female. Three pregnancies. Normal menses.

Figure 2 shows lobules of similar size, shape, and consistency (in each breast). Distribution fairly even. Sector density equal. Lobules parallel. The comparative study shows slight variation in pattern in outer central sectors. Lobules in the left breast, are more vertically placed while in the right breast they are more horizontal. However, ths variation is within normal limits.

Interpretation: Normal Topogram

Case 3. A 52 year old married woman, several years postmenopausal.

As indicated in Figure 3, the lobules have atrophied in all but the infra-areolar portions of both breasts. Shaded portions represent remaining stroma which is smooth and relatively firm. Patterns identical.

Interpretation: Normal woman postmenopausal topogram.

Case 4. A 58 year old married woman who had a hysterectomy 25 years ago.

Figure 4 shows atrophy of all palpable lobules with accompanying atrophy of stroma.

Interpretation: Normal topogram in a surgical menopause.

Patterns in Fibrocystic Disease

Fibrocystic disease (chronic cystic mastitis) presents an irregular topographic pattern. The lobules vary considerably in size, shape, and consistency along with the intervening areas of fibrous tissue. The cysts vary in size. Usually both breasts are involved. If only one breast is affected, this is cause for greater suspicion in regard to malignancy.

Case 5. A 30 year old married woman with normal menses.

Figure 5 shows lobular irregularity in both breasts. In the left breast, note the lobular polymorphism with enlarged lobules progressing to cyst formation in the inner half of breast and to a lesser extent in the outer central sector. There is also slight loss of parallelism. An enlarged lobule is present in the right breast in the upper outer sector There is a slight tendency to polymorphism of lobules in the upper central sector.

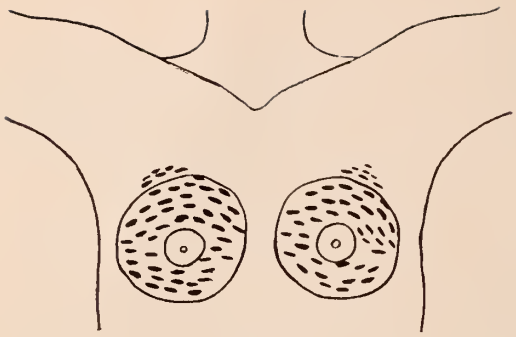


Figure 1

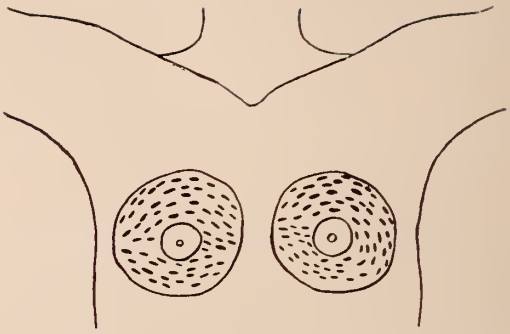


Figure 2

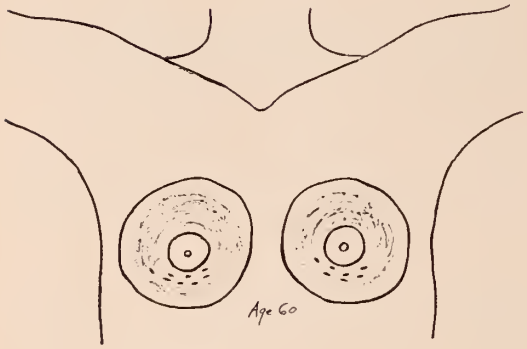


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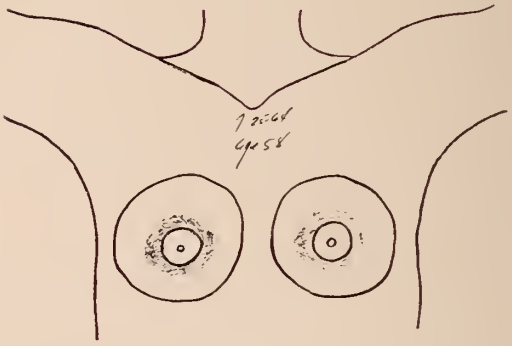


Figure 4

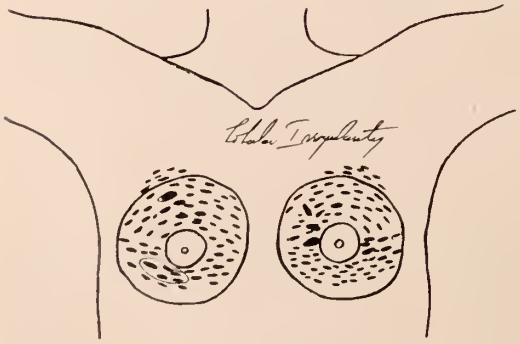


Figure 5

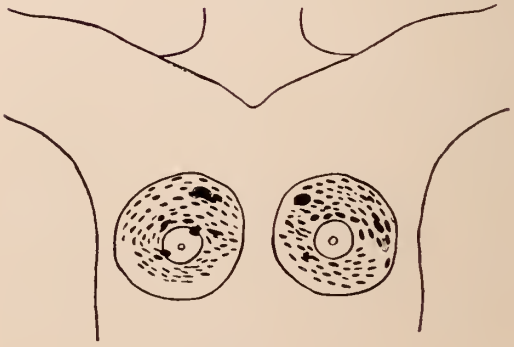


Figure 6

Case 6. A 25 year old married female with normal menses.

A more advanced case of cystic disease, shows in figure 6, a diffuse pattern of bilateral polymorphism indicative of cyst formation.

Case 7. A 29 year old married female. One pregnancy. Normal menses.

Figure 7 shows cystic disease bilaterally. Note that lower sectors of breast are very little involved.

Fibroadenomas

Fibro-adenomata present a fairly uniform pattern as shown in the following two cases:

Case 8. A 35 year old married female had a firm 4-centimeter freely moveable mass, non-tender, in the outer central periareolar region of the right breast. Excisional biopsy revealed a fibroadenoma.

Figure 8: — Except for the mass in the right breast, the topographical pattern is not remarkable.

Case 9. A married 21 year old female. Cesarean section two months ago.

This woman noticed "lumpiness" in left breast during 2nd trimester of pregnancy.

Figure 9 shows a slight variation in the lobular pattern in upper half of left breast where a 25-millimeter freely moveable, non-tender, firm tumor was present. Excisional biopsy revealed a fibroadenoma.

The Benign Solitary Lobule

In the topographic examination of the breasts, a single lobule may often be palpated which has physical characteristics that are distinct from the lobules surrounding it. Such disparate characteristics include size, shape, consistency, and mobility. For the want of a better term, we have designated these lobules as solitary or "lookout" lobules. Gradations in size of lobules are present in different sectors of the breast, to be sure. However, the solitary lobule (of which size and increased firmness are the distinguishing characteristics) stands out in distinct contrast to the juxtaposed lobules. These benign solitary lobules may remain stationary or increase in size to form cysts or solid tumors. Case 10 shows a slightly enlarged solitary lobule in the left breast of about 4-millimeters in diameter which was freely moveable and slightly tender.

Case 10. A married 31 year old female. Normal menses. One normal pregnancy.

Figure 10 shows a normal pattern except for the enlarged lobule in the left breast which was neither firm nor fixed. It is beng currently observed.

Carcinoma of the Breast

1. *Asymmetrical Lobular Atrophy*

During or after the menopause, there is usually an orderly symmetrical atrophy of lobules so that the topographic pattern of the breasts are mirror images of each other. This atrophy progresses in such a precise fashion that any asymmetrical change immediately suggests a pathologic state. There were four cases in this group.

Case 11. A 37 year old woman.

This was a married woman with a 35 millimeter mass in the left breast of several months duration. There was slight fixation of the mass to the deep fascia.

Figure 11 shows an area of lobular atrophy (bare area) in the upper inner quadrant of the right breast. Biopsy of the lesion in the left breast revealed adenocarcinoma.

Case 12. A married 40 year old female. Four pregnancies.

This woman had had four normal deliveries and now showed early menopausal symptoms. She noted a "lumpiness" of right breast two months prior to examination.

Figure 12. Topography shows a complete absence of palpable lobules in left breast. In the right breast there is a distinct lobular pattern in the upper and lower central sectors in addition to a 3 by 2 centimeter area of lobular polymorphism with increased firmness suggestive of cystic disease. Biopsy revealed a focus of infiltrating duct carcinoma in a mass of fibrocystic disease.

Case 13. A 53 year old female. No pregnancies. Hysterectomy 25 years ago.

This woman had a 5 by 2½ centimeter firm mass in the upper central sector of the right breast. The mass was non-tender and slightly fixed to the deep fascia.

Figure 13 shows marked asymmetry in lobular pattern characterized by near complete atrophy of lobules in the right breast. Excisional biopsy revealed a 1.5 cm. diameter tumor identified histologically as a giant follicle lymphoma.

Case 14: A 38 year old married woman.

A 38 year old woman with normal menses, dicovered a mass in the right breast four weeks previously. Examination disclosed a 3.5 by 2.5 centimeter mass, a firm, moderately fixed tumor in the lower half of the right breast.

Figure 14. Topography shows "bare areas" of lobular atrophy in the upper inner and lower outer sectors of the right breast. Biopsy revealed adenocarcinoma.

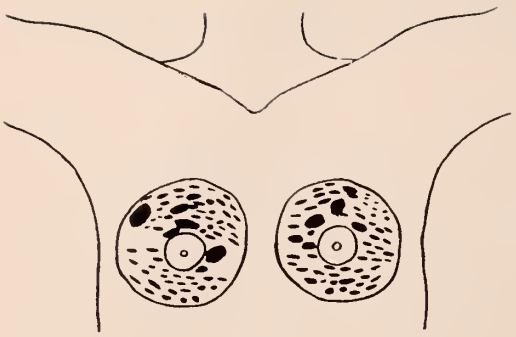


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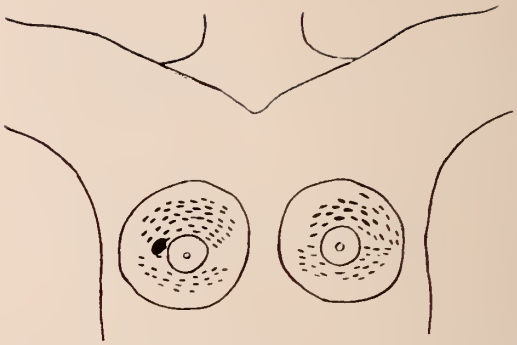


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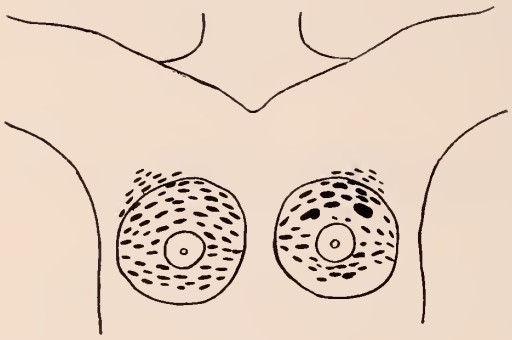


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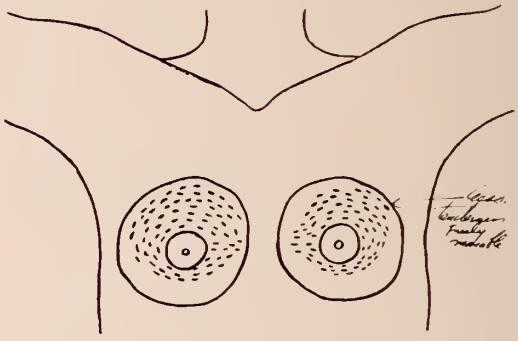


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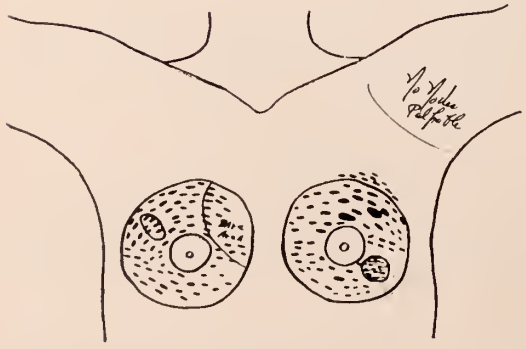


Figure 11

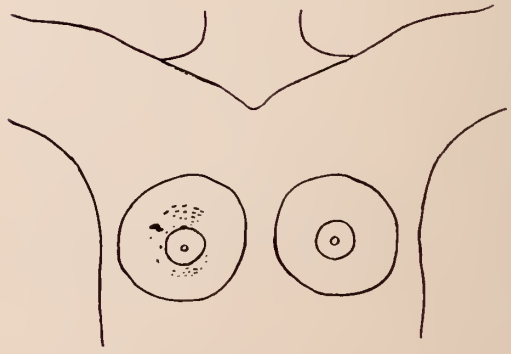


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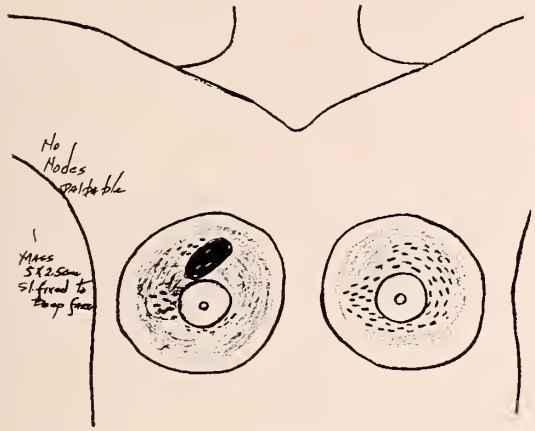


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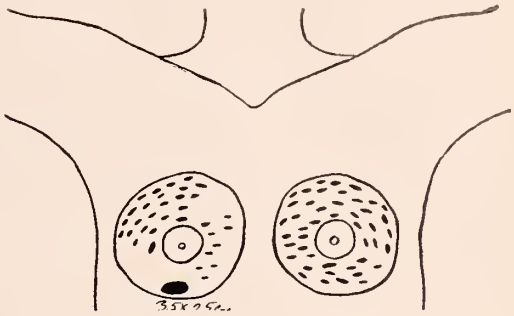


Figure 14

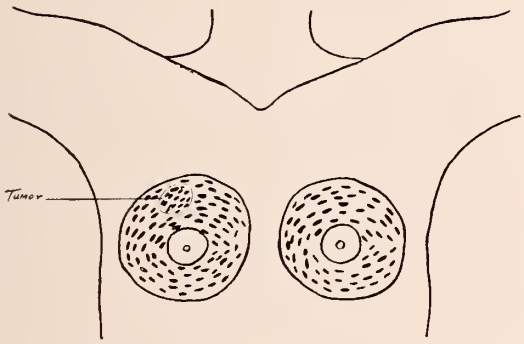


Figure 15

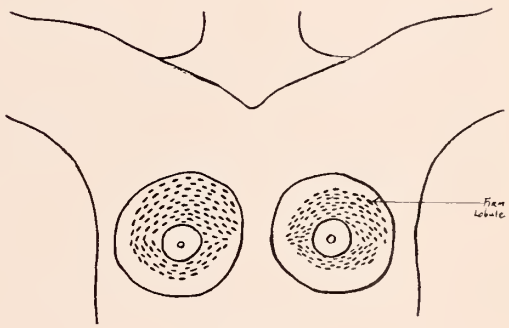


Figure 16

2. *Localized Lobular Differentiation*

There were three patients in this group. The pattern was that of localized lobular differentiation which was delineated in the form of a mass. Varying degrees of localized lobular differentiation may be found in mammary gland topography, the degree of change may suggest the degree of pathology. The following case is typical:

Case 15: A 27 year old married woman.

A 27 year old female had an ill-defined area of lobular irregularity in the upper central sector of the right breast measuring nine centimeters in diameter. It was moderately moveable. Biopsy revealed a non-infiltrating duct carcinoma.

Figure 15 shows an area of lobular differentiation in the upper central sector of the right breast.

3. *The Malignant Solitary Lobule with No Pattern Change*

We may infer that at one stage in its growth, the lobule in which the carcinoma has its inception was no larger than the surrounding lobules. However, as a result of epithelial proliferation and fibrous response accompanying the malignant change, these structures very early develop a distinct firmness and a degree of fixation which are palpably detectable. These changes may occur even prior to an increase in size.

It is at this early stage of development of cancer in a lobule that we think a number of breast tumors are not detected clinically. In these instances, topography should play a

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significant role in early discovery.

Case 16: A 47-year old woman with a solitary lobule.

A 47 year old married female on routine physical examination was found to have a 5 millimeter solitary lobule in the upper outer sector of the left breast near the periphery. It was only slightly larger than the surrounding lobules but had the distinguishing feature of increased firmness and slight fixation. Excisional biopsy showed an infiltrating duct carcinoma, productive fibrosis type. A radical mastectomy was done. No involved axillary nodes were found.

Figure 16 shows the slightly enlarged malignant lobule in relationship to the surrounding lobules.

Conclusion

1. Mammary gland topography is the digital examination and concommitant recording of the lobular surface anatomy of the mammary glands, including characteristics of the individual lobules. Preliminary studies of 1000 cases have suggested that this surface anatomy forms significant patterns and findings in normal pathologic and in impending morbid states, when one breast is compared with the other.

2. Since palpation remains the most practical and universal method for the discovery of breast neoplasms, this type of detailed examination offers an additional advantage in the early discovery of breast lesions and, even more importantly, as an indicator of impending disease.

3. Also in breast self-examination, using this comparative method of topographical examination, the woman is better able to ascertain the presence or absence of a mass.

Acknowledgement. The author here records his thanks to the physicians and staff of the laboratories of the Newark Presbyterian Hospital.

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18 South Eighth Street

The Falling Infant Death Rate

The nation's infant death rate continued to decline during the first half of this year, according to the National Center for Health Statistics. The rate is calculated as the number of deaths of children under one year per 1,000 live births. It went to a new low of 22.9 in the first six months of 1967. There has been a decline every year since 1958. From 1958 to 1966 the infant death rate dropped from 27.1 to 23.4 per thousand, a decline of 13.7 per cent.

Government officials predict the death rate will continue to drop in coming years. As factors they cite:

Increased family income, bringing better nutrition and health care.

Increased emphasis on early access to high-quality medical care.

Greater availability of prenatal medical services.

The spread of family-planning services.

A higher level of education.

Influenza and pneumonia (except pneumonia of the newborn) were the only causes of death among infants that declined markedly during the first half of 1967, compared to the same period in 1966. The decline from other causes of death was slight, but general.

Socrates commented on the bad manners of children and the disrespect shown by adolescents. And that was 2200 years ago!

Getting Our Children Through Adolescence*

And Surviving—If We're Lucky

William L. Peltz, M.D./Philadelphia

A few weeks ago a man told me that his 15-year-old daughter was failing all her subjects and had become much attached to a young boy. He and his wife were understandably concerned because their older married daughter had become pregnant by an older boy who was a dropout and drifter. She had had an abortion and subsequently lived with a drug addict. They then began exploring the possibility of boarding schools for the younger daughter with the hope of preventing another tragedy in the family. When they mentioned the idea to her, the girl said: "Oh, Daddy, I don't want to go to a boarding school, and if you do send me to one, I'll run away and get an apartment for myself and take LSD."

Not long ago, I asked a 16-year-old boy who was experiencing anxiety symptoms what he would wish for if he could have any wish come true. He replied that he would like to have the world last long enough for him to live out his lifetime. And then there are the three adolescent patients on my service in the Univerity Hospital at present, all three of whom have made suicidal attempts. Two of them are long-haired, one with sideburns and the other one bearded.

And here is a quotation which some of you may recognize:

"The children now love luxury; they have bad manners, contempt for authority, and show disrespect for elders. They love chatter in place of exercise. They no longer rise when elders enter the room. They contradict their parents, chatter before company, gobble up dainties at the table, cross their legs and tyrannize over their teachers."

That was written by Socrates 2200 years ago.

In other words, problems with the young are not new. But they are certainly different, and there are so many more adolescents, too. "In the United States, citizens of 25 and under in 1966 nearly outnumber their elders; by 1970, there will be 100 million Americans in that age bracket."[1]

Perhaps in considering the behavior of adolescents it is helpful to think in terms of a spectrum. At one extreme is the goody-goody whom you would like to take a poke at sometimes. Next, comes the ideal kind of youngster you'd like to have as a son or daughter — well behaved, capable, and responsible, but at the same time interesting, good fun, and very human. Next is the one who hacks around somewhat more than desirable, but not to any serious degree. You worry about him, but in the long run he will probably turn out all right. Then comes the boy or girl about whom you really begin to worry because he does more than just hack around. He gets in real trouble, at least occasionally, whether in a scholastic or disciplinary way at school, whether he gets put on warning or is actually dismissed, or whether he occasionally has a run-in with the police, perhaps for speeding or because of drinking. He is

* Presented at the New Jersey District Branch of the American Psychiatric Association meeting in Newark on March 15, 1967.

rebellious against authority, doesn't dress the way his parents wish he would, and probably goes around with a crowd they disapprove of. They worry about his behavior, as well as his morals. They expect the psychiatrist to straighten everything out, and are probably critical of psychiatry when he fails to do so. And finally comes the extreme other end of the spectrum—the psychotics and delinquents — the boys and girls who are in serious trouble within themselves, or with their environments, their parents, their schools, their communities, the law.

Most of the boys and girls I see fall in the middle range of the spectrum—the youngsters who are having problems with their studies or their behavior in one way or another. The boy and girl who has an I.Q. of 120 to 135 but who is flunking or is barely passing two or three subjects; the youngster whose attitude and conduct are a worry to his family and school but who is not in any serious trouble, the potential dropout. And just a sprinkling of the extremes of the spectrum — at one end the basically sound youngster who is upset because something has gone wrong in his environment, and at the other end, the psychotic, the drug addict, the sexual deviate.

This is rather similar to the parts of the spectrum that are seen in any university health department. In a series of 184 students being seen by psychiatrists in one university student health department, we are told that the most frequent types of problems that were referred for help were: work that had fallen below expectations; psychoneurosis of various kinds; cyclothymic conditions, mainly depressions; disciplinary problems; suicidal preoccupations; sex difficulties; and feelings of inferiority. Whenever a college or university establishes a psychiatric unit, legitimate demands for its services far exceed the facilities available.[2] Existing student health reports indicate that about ten per cent of student bodies request help for emotional problems during any college year.

At such places as the Reception Center in Philadelphia, almost all of the adolescents are brought there because of difficulties with the law and practically all of them fall in the very extreme end of the spectrum — the asocial and dyssocial personalities, the delinquents, the psychotics.

In the adolescent unit of the closed section of the Pennsylvania Hospital about half of the adolescents have been diagnosed as schizophrenic and about half of the remaining half as borderline schizophrenic.

The title of this presentation is intended to make us ponder about parents getting their youngsters through adolescence — and surviving! Youngsters of all sorts, from all parts of the spectrum.

The question is really not whether the parents can survive — of course they can — though sometimes they may agonize and may even wonder as to whether or not they will. The question, rather, is whether the adolescents can survive — and again, my answer is that they can, too — most of them, anyway. Some may stumble and some may flounder along the way, and unfortunately a certain number will succumb in one way or another, but most will not only survive but will reach the levels of adjustment and success which is appropriate for them. And in some cases, as they struggle to find their identities and to become emotionally independent, to reach mature levels of sexuality, to develop principles and values which will be meaningful in living with and relating to other people, and in deciding and learning how to earn their living, the levels that they reach are truly remarkable. Obviously, however, there are internal conflicts and external pitfalls along the way which have to be met and coped with.

All the adjustments and maladjustments of the adolescent years are attempts to cope, however successfully or unsuccessfully, with stresses, strains, pressures, and conflicts that their young egos are experiencing or are being subjected to. This implies an imbalance of the psychological homeostasis or equilibrium which the ego tries to maintain. The

imbalance may exist because the ego is still in the process of development and hence is incapable of fully mature self-control, will power, and stability. Or it may be because of inner psychological conflicts; or because of external pressures impinging upon the ego. Most often it is because of a combination of several, or even all, of these factors.

As regards the inner psychological conflicts, the imbalance may result from conflicting impulses arising from the id and the superego. For example, there obviously occurs a marked increase in libidinal urges during adolescence and also an increase in hostile competitive drives which lead to rebellion against authority. These come in conflict with the demands of the superego which during these years is usually fairly well developed (except in the dyssocial individual).

This, together with the fact that at that time of life the ego is still weak and "ungelled," explains why the behavior of adolescents can be so perfect and ideal at one moment, and so erratic and outrageous the next.

Internal psychological conflicts can occur not only from the forces emanating from id and superego, but also from pairs of opposites. For example, symptoms can be understood and explained by expressions of conflict between sadistic and masochistic drives, active and passive or masculine and feminine strivings, or heterosexual and homosexual urges. One striking example of this is (in addition to whatever conflicts with parental authority may exist) the internal conflict between one's desire to master the environment and to be independnt on the one hand, and one's inner passive-receptive dependent needs on the other.

Imbalance in psychological homeostasis or equilibrium may arise not only from internal conflicts between the psychological components but also from a multitude of external environmental pressures with which the ego tries unsuccessfully to cope. There are, for instance, conflicts with parents, the influence of peers, the pressures of school and college, illness, the draft, vocational difficulties, the dissatisfaction with the goals and ways of life that earlier generations have struggled for. Such external environmental factors lead to all sorts of uncertainty, conflict, confusion, insecurity, and disillusionment. This includes the disillusionment with what may be thought of as "cocktail suburbia." It encompasses confusion in a world of changing values — values that relate not only to what constitutes success, but that have to do with patriotism, civil rights, and the very meaning of life. It covers the intense struggle for survival in a dog-eat-dog jungle, where the population explosion is terrifying in its implications for the future.

There are temptations for them to hearken to Doctors Leary and Alpert and their disciples in hope of finding new answers through psychodelic dimensions with LSD; or to seek escape from the world of reality into a dreaming pseudo-nirvana through pot. And they may suffer confusion from unhappy homes or broken homes, deprivation of love, and from excessive affluence; or confusion associated with the uncertainties of the future, from the threat of the draft, of a crazy war, of sudden and unpleasant death at an early age, and for a cause that many of them do not believe in.

The next questions of importance in gaining an understanding of our adolescents are to see how they react to their conflicts and confusions and, if possible, to see why they react in their particular ways. This leads us to another parameter of psychodynamics — namely, the fact that the ego utilizes one or another of the mechanisms of defense in its efforts to maintain psychological homeostasis and to cope with conflicts arising within the psychic apparatus or stemming from the external environment.

The behavior or clinical symptoms of the person are determined by the particular mechanism or combination of mechanisms he utilizes. For example, even though repression may be used, anxiety or panic may be experienced as such. Compulsive behavior and obsessive thinking are often associated with

reaction formation and denial; chip-on-the-shoulder attitude or actual paranoid thinking with projection; depressive symptoms, guilt and suicidal tendencies with introjection. And perhaps most common of all during adolescence, acting out of hostile urges may be observed in the form of rebellious behavior manifested as under-achievement in school work, laziness, untidiness, long hair, becoming beatnik, disciplinary problems or delinquency, or sexual maladjustment of one sort or another. If the conflict is so great that the ego cannot tolerate it, a schizophrenic break with reality may occur.

In connection with the acting out of hostility and aggressiveness, it may be of some interest to mention that it has been reported that more crime is committed by 15 year olds than by any other age group — and next frequently by 16 year olds. Wertham[3] has stated that in explaining violence and crime it is not sufficient to think in terms of inadequate mothers or revolt against toilet training. Violence, he says,[3] is never an isolated factor, and it can never be explained entirely by the psychology of the individual. The environment and the toleration of violence in the environment play vitally important roles with the result that violence can spread like a contageous disease. It is said, for example, that within six weeks of the murder of the eight nurses last July, 46 other people were killed in mass murders.

We need to learn as much as possible about the inheritance and conditioning during the earlier years of the person's life, with particular reference to the relationship with parents, siblings, and other important people in the early life-setting. The characteristics and ways of reacting of these people must be understood in view of the positive and negative feelings and the identifications which inevitably occur during those formative years. During early years, the specific emotional vulnerabilities arise which so influence one's later life to such extraordinary degrees. Hence, for example, if a person felt neglected, threatened, and insecure during his earliest years (with frustration of the passive, receptive dependent needs that all people have) he is more likely to over-react or react adversely or peculiarly to threats to his security during adolescence or thereafter, and he is likely, too, to react in ways which are akin to his early reactions. Likewise, over-indulgence during the early years or discipline that has been too strict or too lax, or that has been inconsistent, can obviously all lead not only to difficulties in early life but to patterns of reaction and maladjustment which will be manifested in characteristic ways during adolescence.

It may be that a knowledge of psychodynamics should help us understand adolescents better, and that such understanding should enable us to be better parents and better therapists. Of the latter I have no doubt, but of the former I am far less sure — for if such be so, who but psychiatrists and psychologists and the so-called experts in the field of child rearing such as Benjamin Spock would have half a chance of raising their adolescents successfully? And I am not at all sure that the children of men and women working in these fields are any better adjusted than the children of our non-psychiatric colleagues, or of ministers, teachers, or lawyers. A controlled study along such lines would be interesting — though not necessarily comforting to us.

At this point let us turn our thoughts back to the cases I referred to briefly at the beginning of this presentation: the school girl who was an under-achiever, who was overly involved with a boy and was threatening to run away and take LSD; her older sister who drank and who had become pregnant by a boy who was a dropout and a drug addict; the anxious boy who was worried about the continuation of life on earth; and the boys and girls, beatniks or otherwise, who decide that life is not worth living.

School problems, sex, psychedelics, suicide and survival — and drinking and dropouts — as well as the observations of Socrates.

In recent years a change has been going on in the sex standards and sex behavior of

young people. We hear a great deal about permissiveness with affection, the single standard and the so-called "new morality." When asked what was meant by the "new morality," someone asked, "Isn't it just what has always been known as immorality?"

The answer to that "No."

It is a *new* kind of morality, and very different from the old version. It implies greater honesty about sexual relations than has existed heretofore, with concern about fidelity and consideration for others rather than concern about chastity or virginity. If intercourse is all right for the boys before marriage, it is considered to be all right for the girls; and it is considered to be quite all right as long as one really cares for the other person. In spite of the high ethical component that is attributed by those who adhere to these views, parents and others who are in positions of responsibility for young people experience very considerable concern regarding the implications and possible results. And the younger the teenager is, the greater the concern — most understandably it seems to me.

Studies indicate that in spite of rumored reports of increase, there has actually been no increase in the rate of pre-marital intercourse among males or females in the past 25 years. The explanation for the *apparent* increase in rate is that these things are talked about more openly now and that there has been an enormous increase in the actual number of young people, and therefore in the number of them having premarital intercourse, even though the rate has stayed the same.

Second, there is the problem of suicides among adolescents, especially during the college years. The statement is sometimes made, too, that there has been an alarming increase in the rate of suicide among college students. However, after a meticulous study, Farnsworth[4] was unable to find any evidence of such an increase.

Suicidal attempts or gestures are frequently sudden reactions to stressful situations resulting from frustration, depression, or anger. They may be rebellious acts against a restraining and, frequently, loved person. A high proportion of the adolescents who attempt suicide come from unstable or disorganized homes.

A warm, personal relationship between the suicidal person and others who are interested in him and who care for him is the best protection against suicide. It is, therefore, important for school and college administrations and faculties to acquaint themselves with troubled students and to be readily accessible to them for the establishment of therapeutic contact.

How about college dropouts? Farnsworth[4] reports that the dropout rate in American colleges and Universities has remained strikingly constant through the last four or five decades. One study from 1913 to 1962, and other studies that have covered the decades since the 1930's indicate that the number of those who failed to graduate from college has usually been about 60 per cent. The great changes have been in the reasons for the dropouts, the attitudes toward them, and (because of the increase in college student population) in the actual increase in number though not in the dropout rate.

And then, of course, there are all sorts of problems connected with drinking. After all, cocktails and cocktail parties are a relatively new phenomenon on the American scene. Until the 1920's when the orange blossom was introduced (a mixture of bathtub gin and orange juice, as I recall), it is my impression that cocktails were unknown. Now they are a regular part of the everyday life of millions upon millions of Americans. Teen agers who want desperately to be grown up and who see their parents drinking regularly (and not infrequently drinking too much) start drinking at an early age. And to make matters worse, although our sons, when under 21, are old enough to fight and die in Viet Nam, they are prohibited by law in many states from drinking. Thus many of them

grow up feeling it is appropriate to break the law — as millions of adults did during prohibition. Whether such laws actually reduce the number of tragedies on the highways and elsewhere while under the influence of alcohol, I do not think anyone can say with any degree of certainty.

At a summer resort that I know very well some youngsters had a few drinks one night and stole a car. The police were involved and it got pretty sticky. Naturally the parents became concerned. "Let's meet for cocktails at noon tomorrow and figure out what to do about it," they decided, without realizing that there was anything inappropriate about their meeting in connection with it over cocktails.

I cannot offer a quick recipe as to how, as parents, we might solve all the problems of adolescence. I hope you will not consider it condescending of me to mention the importance of warm, loving homes, of parents setting good examples, of offering sound guide-lines, of communicating, of setting limits, of encouraging independence but of insisting that children and adolescents assume the responsibilities that go with their privileges. But be assured that even if all of these things are carried out to perfection, adolescents will have problems and so will the parents of adolescents. I do not know of any family with children who does not have at least some degree of worry or problem when the children go through the adolescent years.

It is a stormy time for all concerned, but a challenging and an interesting time, as well. Shakespeare in *The Winter's Tale* had something to say along the latter lines:

"I would there were no age between ten and three-and-twenty, or that youth would sleep out the rest: for there is nothing in the between but getting wenches with child, wrong-doing the ancientry, stealing, fighting."

When asked what suggestions he would make regarding bringing up adolescents, and how to survive the process, one person replied:

"Parents ought to have a practice run — sort of a dry run, as it were — on bringing up someone else's adolescent before they bring up their own."

And another person said:

"They're going to rebel against authority no matter what you do; the only really sensible solution is to put them in deep freeze until they grow out of it."

A well-known songwriter of so-called popular songs once phrased it this way for the title of a song which, as I recall, never got written: "Bury 'em at Twelve and Dig 'em Up at Twenty."

At best, adolescence is not an easy time and in this day and age with Viet Nam, the atom and hydrogen bombs, the population explosion, the pressures involved in getting into college, it is less easy than it was 50 or even 25 years ago. The days of Dick Stover and Frank Merriwell are gone forever.

The Yale College song "Bright College Years" says:

"Bright College Years with pleasures rife, the gladdest, brightest years of life, how quickly are ye gliding by! Oh, why does time so swiftly fly?"

It was a wise professor in New Haven many years ago who told his class, "Gentlemen, that's a lot of baloney. These are not the gladdest, brightest years of your lives. That is the old grad trying nostalgically to recapture his lost youth. Thank God, for you and for us, too, that the best years of your lives are still ahead."

With those wise words I will leave you, suggesting that we recognize that parents and adolescents have had problems connected with the adolescent years as far back as the days of Socrates and of Shakespeare. In spite of psychiatry the world will probably still be having them a hundred and a thousand years from now. Perhaps, through psychiatry we can understand a bit more about the psychodynamic reasons for the problems of adolescence than was the case in the past. In spite of this, there is little if any evidence to indicate that parents are coping with these problems very successfully. Adolescents are going to continue to grow into adulthood whether or not we like the way they do so. There is every likelihood of our being able to survive

in spite of our adolescents and of our adolescents surviving in spite of us as their parents. Through our growing concern and our greater understanding, through the efforts of somewhat more enlightened parents, and through the work being done by psychiatrists, psychologists, and social workers in therapy, counseling, and prevention, let us hope that the adolescents will not only survive but will produce an even better world than we have today — which isn't too bad a one when you compare it to what the world was like and what the lot of human beings was like a few thousand or a few hundred years ago.

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Chronic Disease More Frequent In Heavy Drinkers

Chronic, heavy drinking apparently confers some protection against kidney stones—if the drinker is willing to accept a higher-than-average risk of cirrhosis of the liver, hypertension, and other chronic diseases. This relationship between "problem" drinking and chronic disease appeared in a statistical survey of nearly two thousand problem drinkers and non-drinkers, or persons for whom drinking is not a problem.

Details of the survey and its results were reported at the American Medical Association's 116th Annual Convention in Atlantic City last June. Biostatisticians Sidney Pell, Ph.D., and C. A. D'Alonzo, M.D. (Wilmington, Del.) drew the material for the survey from the medical records of nearly two thousand employees: 922 who were known or suspected to be problem drinkers and an equal number for whom drinking was not known to be a problem.

All employees had regular examinations. The records selected for the study were culled from 76,687, representing patients under close enough medical surveillance to detect alcoholic tendencies. The survey showed that, of the 922 known or suspected problem drinkers, 333 had hypertension. Among the "control" group of 922 non-problem drinkers and non-drinkers, only 148 were hypertensive. Cirrhosis of the liver was found in 29 of the problem drinkers and in only one person from the control group. Stomach ulcer was found in 74 drinkers and 39 controls; duodenal ulcer in 106 drinkers and 78 controls.

Chronic diseases which appeared more often in the drinking than the control group included: coronary heart disease, cerebrovascular disorders, nephritis, asthma, chronic bronchitis and emphysema, diabetes, gout, and neuritis.

Only in the category of kidney stones did the drinkers score lower than the controls: 32 cases to 55. Whether alcohol should be given credit for protecting against kidney stones is debatable. Alcohol, of course, increases urine output, but the heavy user of alcohol also eats less of the protein and calcium-containing foods associated with kidney stone formation.

Heavy drinking also may be associated with nutritional deficiencies, use of other drugs, psychosomatic disorders, and a disorderly way of life in general, which may lead to neglect of basic health habits.

Corticosteroid therapy led to a dramatic response in this almost unique case of huge hepato- and splenomegalic sarcoidosis.

Regression Of Sarcoid Hepatosplenomegaly On Corticosteroid Therapy*

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Many case reports have described sarcoid lesions in nearly all organs of the body. Many rare cases have been described, to which the following unusual case history seems worthy of being added.

A 38-year-old woman was admitted to the Perth Amboy General Hospital on October 23, 1966, with a 12-month history of recurrent fever, vomiting, abdominal distension, and weight loss. She had been in excellent health until one year previously, when she suddenly developed high fever, chills, and profuse sweating. This had persisted for several hours. Similar febrile episodes recurred almost daily until admission to the hospital. Six months before she came in, she had noticed progressive abdominal distension, associated with general weakness and vomiting. Her weakness progressed to the point where she became bedridden. There was no history of hematemesis or melena, alteration in bowel habits, or change in the color of the urine or stools. She had lost 25 pounds in weight in the twelve months preceding entry to the hospital.

On admission, she was weak, obviously sick, and necessarily bedridden. She showed evidence of substantial loss of weight. The abdomen was distended. The edge of the liver was palpable three fingerbreadths below the right costal margin and was firm, but not tender. The tip of the spleen extended to the left iliac crest. The remainder of the physical examination was within normal limits.

The hemoglobin was 11.4 Grams per 100 milliliters; the hematocrit level 34 per cent; white-cell count (WBC) 1,500/cu mm with 90 per cent neutrophils and 10 per cent lymphocytes, the platelet count was 185,000; erythrocyte sedimentation (ESR) was 44 millimeters in an hour; serum iron was 51 micrograms, iron-binding capacity was 284 micrograms per 100 milliliters with 18 per cent saturation. Prothrombin time was 15.2 seconds (control was 11.8); the cephalin flocculation was 3 plus at 24 and 48 hours; bromsulfalein retention was 21.5 per cent in 45 minutes. The protein was 9.8 Grams. The albumin represented 2.3 of these Grams per 100 milliliters. Albumin-globulin ratio was 0.31. Serum electrophoresis revealed that the albumin was 2.31 Grams per 100 milliliters. Beta globulin was 1.50 Grams and Gamma globulin was 4.74 Grams. Reticulocyte count was 2.2 per cent. A direct Coomb's test was weakly positive. Stool was weakly guaiac positive.

The following studies gave negative or normal results: urinalysis, sodium, potassium, chloride, carbon dioxide, urea, sugar, calcium, phosphorus, bilirubin, carbon dioxide tension, pH, glutamic oxalacetic transaminase, glutamic pyruvic transaminase, lactic dehydrogenase, Lee-White coagulation time, three L. E.-cell tests, serologic test for syphilis, sickling of the red blood cells, malaria, blood culture, febrile agglutinins, test for tularemia, Bence-Jones protein, Sia test, tuberculin, and histoplasmin skin tests. Examination of an aspirated specimen of bone marrow showed megakariocytic hyperplasia with all forms of maturation. Myeloid-erythroid ratio was 2:1.

Electrocardiogram was normal. The chest appeared normal by x-ray. No hilar or paratracheal lymph node enlargement was seen. A film of the abdomen demonstrated hepatosplenomegaly. Gastrointestinal series showed displacement of the entire stomach to the right by the huge spleen. Also demonstrated was massive liver enlargement (Figure 1).

Liver biopsy (Figure 2) showed several granulomata consisting of multinucleated giant cells, epitheloid cells, and lymphocytes. There was no evidence of necrosis. Staining of the biopsy specimen failed to reveal acid-fast bacilli or fungi. The liver biopsy was consistent with the diagnosis of sarcoidosis. Biopsy of the skin test made with Siltzbach-Kveim antigen (Figure 3) showed several granulomas also consistent with the diagnosis of sarcoidosis.

Five hours after admission the patient's temperature rose to 101.4. This persisted for four hours. Her hospital course was characterized by a recurring high remittant fever with temperatures to 103.6, accompanied by chills, and by persistance of vomiting.

No specific therapy was given initially. After the liver biopsy, on the sixth hospital day, she was placed on prednisone in doses of 40 milligrams a day. Shortly thereafter, she showed dramatic response. In 24 hours, the febrile episodes and vomiting had ceased. In 48

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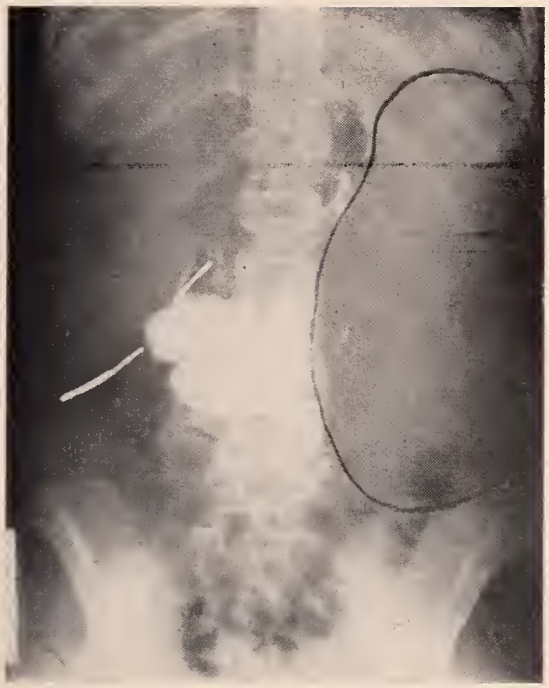


Figure 1. Gastrointestinal roentgenogram demonstrating displacement of the entire stomach to the right by the huge spleen and also showing a massive liver enlargement.

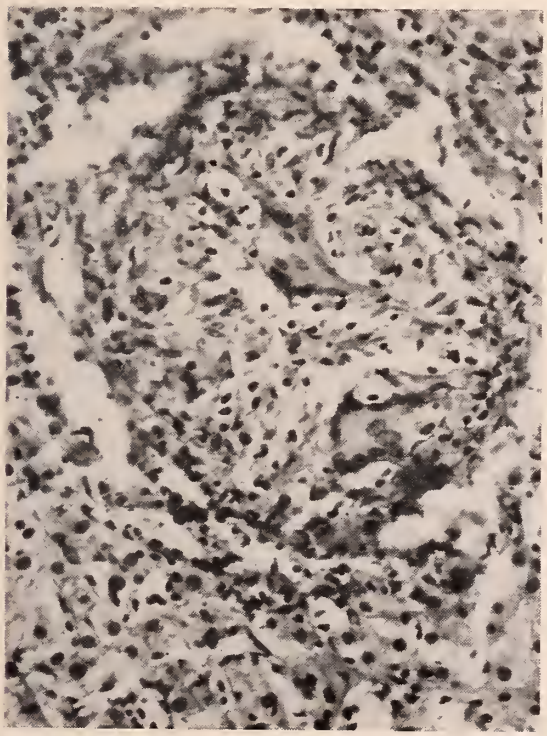


Figure 2. Liver biopsy showing the presence of a granuloma consisting of multinucleated giant cells, epitheloid cells, and lymphocytes. No evidence of necrosis (hematoxylin and eosin, X400).

hours, she had no abdominal distension, regained her strength, became ambulatory, and had an excellent appetite. After 72 hours there was a remarkable reduction of the size of the liver and the spleen. The liver was no longer palpable and the spleen diminished in size, with its tip palpable just below the left costal margin. Prednisone was gradually reduced to 20 milligrams a day.

The patient was discharged on the fourteenth hospital day, asymptomatic, afebrile, and feeling well. On the day of discharge the hemoglobin level was 11.3, and hematocrit was 37 per cent. White cell count was 2,700

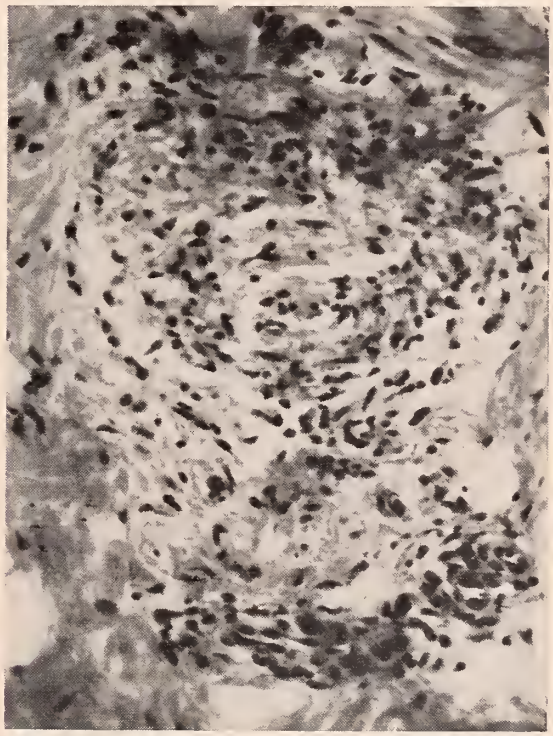


Figure 3. Skin biopsy showing a granuloma consisting of epitheloid cells and lymphocytes. No evidence of necrosis (hematoxylin and eosin, X400).

with 86 per cent neutrophils, 8 per cent lymphocytes, 2 per cent monocytes, and 4 per cent atypical mononuclear cells. The ESR was 28 millimeters, total serum protein 9.8 Grams (albumin accounted for 3.13) with an albumin-globulin ratio of 0.47. Serum electrophoresis showed that the albumin was 3.13 alpha[1] globulin 0.33; alpha[2] globulin was 0.74; beta globulin was 1.15; and gamma globulin was 4.45 Grams. After discharge, prednisone was gradually reduced to a maintenance dosage of 5 milligrams a day.

On a follow-up examination on November 22, 1966, the patient continued to be well and was free of symptoms. She had gained 11 pounds and resumed her normal occupation. On physical examination neither the liver nor the spleen was palpable. A film of the abdomen showed no enlargement of the liver or the spleen (Figure 4). At that time, x-ray series showed a normal stomach without displacement (Figure 5). Skin biopsy of the Kveim test confirmed the diagnosis of sarcoidosis. The hemoglobin was 13; leukocyte count 3,050 with 79 per cent neutrophils, 20 per cent lymphocytes, and 1 per cent monocytes.



Figure 4. Roentgenogram of the abdomen showing no enlargement of the liver or the spleen.

On December 2, 1966, the physical findings were unchanged from the previous follow-up. The patient continued to be asymptomatic and was completely well. Her weight was 141, a further gain of 6 pounds.



Figure 5. Gastrointestinal roentgenogram shows a normal stomach without displacement.

Leukocyte count was 4,200 with 72 per cent neutrophils, 26 per cent lymphocytes and 2 per cent monocytes.

This case was unusual because of a unique combination of features: a massive hepatosplenomegaly with high globulinemia and a low A/G ratio. She had severe hypersplenism with severe leukopenia. Furthermore, the patient was continuously ill for one year with persistent severe constitutional symptoms with daily spiking temperature, marked weight loss, and weakness. She had almost constant vomiting. Finally, there was dramatic response to her constitutional symptoms on corticosteroid therapy, with complete disappearance of fever and vomiting within 24 hours. She regained her strength within 48 hours. There was complete regression in the size of the huge liver and spleen within three days.

The clinical course of sarcoidosis is usually chronic, with minimal or no constitutional symptoms. However, acute phases may be characterized by a general reaction with malaise and fever. Severe constitutional symptoms are rare. In a series of 90 patients[1] only three had fever of more than a slight degree. A continuous episode of severe constitutional symptoms of one year's duration with daily spiking temperature, as in our case, was exceptional. Also, while mild gastrointestinal symptoms occur[2] in subjects with hepatic sarcoidosis, frequent, almost constant, vomiting of six month duration is indeed unusual.

Hepatosplenomegaly is reported in 15 per cent of cases of sarcoidosis, but massive hepatosplenomegaly with hypersplenism is rarely seen.[1,2,3,4,5] Leukopenia is a distinct feature of hypersplenism.[1,2,4,5] The lowest previously recorded white cell count in the literature[4] was 1,850, but in our case it was 1,500 per cubic millimeter.

The only agents of proved value in sarcoidosis are the corticosteroids. These are most effective in acute cases.[5] In chronic cases improvement is usually slow[6] and may be expected to take some weeks or months.

In hypersplenism (secondary to sarcoid) the regression of the size of the organ with steroids is usually very slow.[1,3,4,7] Not infrequently, there is no reduction at all. Also, rapid subsidence of constitutional symptoms with hypersplenism is uncommon. For these reasons splenectomy[1] is often more beneficial than steroid therapy.[3]

Summary

A case report of sarcoidosis is presented. A 38-year-old woman developed a huge hepatosplenomegaly with severe constitutional symptoms of one year in duration, with daily spiking temperature, marked weight loss, and severe weakness associated with vomiting. The patient had severe hypersplenism with severe leukopenia and marked hyperglobulinemia. Response to corticosteroid therapy was dramatic. Fever and vomiting disappeared in 24 hours. She regained her strength in 48 hours, and the size of the liver and spleen regressed to normal in 3 days.

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Facts On Quacks

Facts on Quacks, a complete source book touching every aspect of health quackery, is now off the presses. This new book is considered a major instrument in the AMA's program of educating the public to the evils of quackery. It is especially designed for medical society use in their anti-quackery programing. Publication of *Facts on Quacks* marks the first time in history that information on all types of quackery has been consolidated into one book.

The 32-page, two-color, illustrated booklet, written in question and answer form, is beamed at the public and covers facts on health quackery in such fields as arthritis and rheumatism, cancer, nutrition and weight reduction, over-the-counter drugs, alcoholic nostrums, health books and pamphlets, epilepsy, mental health and retardation, cosmetics, baldness, rejuvenation, and sex stimulants. One section advises the reader what he should do if he suspects health quackery activities in his community.

"Never before has there been any book like this," Doyl Taylor, director of the AMA Department of Investigation, says. "It should be placed in every reference library in the country and certainly in every medical library. Every local medical society should see to it that a copy is in each of its local libraries and individual physicians should place copies in their waiting rooms."

Facts on Quacks is being published by the AMA in full cooperation with various governmental and voluntary agencies in the health field, such as the National Health Council, the Food and Drug Administration, the National Better Business Bureau, the Post Office Department, the Federal Trade Commission, the American Cancer Society, Inc., and The Arthritis Foundation. Requests for "Facts on Quacks" should be directed to the Order Department. Singe copies, 30¢; lower prices in quantities.

Is mental retardation usually the obstetrician's fault? "Not guilty" pleads the head of this department at New York's Downstate Medical Center.

Role Of The Obstetrician In The Prevention Of Mental Retardation

Louis M. Hellman, M.D.
Brooklyn, New York

For a long time, non-obstetricians have suspected that most of the problems of retardation in children could be laid at the door of the obstetrician. In all fairness the facts should be allowed to speak for themselves. The factor which bears the largest burden of responsibility is prematurity. Obstetrical trauma is far less culpable. I collected a series of cases of cerebral palsy and found that elective low forceps (designed to shorten labor) had been applied at birth in 30 per cent. This was almost identical with its frequency in the normal control infants (31 per cent). Oxytocin to accelerate delivery was associated slightly more often in cerebral palsy (6.5 per cent) compared with normals (4.7 per cent). Mid-forceps delivery was the method in 7.5 per cent of cases of cerebral palsy compared with normal controls (4.7 per cent). Breech extraction was associated with a still greater incidence of cerebral palsy (9 per cent contrasted with 3.5 per cent in normal controls). Clearly, the role of obstetrical trauma can not be entirely set aside in accounting for damaged babies.

* Dr. Hellman is Professor of Obstetrics at the Downstate Medical Center of the University of New York. This paper was part of a symposium on "The Retarded Child" conducted on April 5, 1967 at the Middlesex General Hospital in New Brunswick, New Jersey. The program was supported by a grant from Merck, Sharp and Dohme and was under the joint auspices of the Academy of Medicine of New Jersey and the Pediatric Society of Central New Jersey.

However, when one compares obstetrical trauma with the factor of prematurity in relation to mental retardation the picture is sharply different. For purposes of this comparison "prematurity" is defined as a birth weight of less than 2500 Grams. With birth weights of 1760 Grams or less, constituting markedly underweight infants, one encounters a striking increase in the proportion of dull, retarded, and defective children.

If prematurity could be prevented the incidence of mental retardation could probably be cut in half. The cause of low birth weight is uncertain in most cases. One of the known causes is twinning, which accounts for 12 per cent of low birth weight infants. An additional 25 per cent can be related to maternal disease, i.e. toxemia, hypertension, diabetes, heart disease, and so forth. Congenital malformation of the fetus accounts for 1.6 per cent. The remaining cases of prematurity, amounting to 62 per cent, are of unknown cause. In this group particularly one finds the highest incidence of mental retardation.

In the search for causes of otherwise unexplained prematurity an abundance of indirect evidence has been accumulated which places particular suspicion on environmental factors, specifically poverty. The incidence of prematurity under poor economic conditions is 2.5 to 3 times that which is found under economically favorable conditions. Prematurity was found to be particularly frequent

among the Negro population, amounting to 17 per cent of all births, contrasted with that of the white population, in whom it amounted to 5 per cent.

The exact role of poverty is still to be elucidated. Lack of prenatal care is the customary explanation, yet no clear cut cause-and-effect relationship has been actually demonstrated. Poor housing conditions are apparently not at fault inasmuch as the same incidence of prematurity prevails in public housing as in unrehabilitated slum areas.

On the brighter side are recent advances in clinical practice which enable the obstetrician to determine whether the fetus is developing at a normal rate. One of these is the discovery that estriol excretion in the gravid female is influenced by the condition of the baby and the placenta. Another is the application of ultra-sound to the measurement of fetal development. In contrast to x-ray mensuration, ultra-sound is without hazard to the fetus. The biparietal diameter of the skull (which can be measured accurately by ultra-sound), can be closely correlated with fetal weight throughout the latter stages of gestation. By these methods, the obstetrician is forewarned of the possibility of a low birth-weight baby or, for that matter, an abnormally big baby for whom early induction of labor may be imperative.

450 Clarkson Avenue

Sore Feet and Silicone Grease

American troops in Viet Nam may have a solution to a problem that plagued soldiers in earlier wars: how to keep wet feet from getting sore. Silicone grease may be the answer, reports the May 22, 1967, Journal of the American Medical Association. When troops spread it liberally on their feet and socks, they were enabled to endure wet feet for several days without suffering the painful, disabling "warm-water-immersion foot." That ailment is similar to what soldiers of World War I and II and Korea called "trench foot." Although the grease seems to help, investigators still aren't certain what causes the problem.

Pain seems to develop when foot calluses expand and contract on wrinkled, water-soaked skin. In Viet Nam, Marines in 1965 reported a high incidence of warm-water-immersion foot. Investigators at the University of Miami, sponsored by the Armed Forced Epidemiological Board, were able to duplicate Viet Nam water temperatures (70 to 75 degree F.) in the Florida Everglades. During this study, the silicone-grease applications were developed. The JAMA reports further testing at the Marine training base at Camp Lejeune, N.C., where it was confirmed that the grease would prevent or retard development of sore feet for several days under combat conditions.

It was long believed that temperature loss to cold water sloshing around in a combat boot was a major cause of sore feet. This view may have to be revised now.

During the Korean War, there was some success in preventing trench foot after insulated rubber boots were developed. The boots were clumsy and didn't really keep feet dry; but their insulation did hold the water at somewhere near body temperature. But subsequent studies have shown that sore feet develop even in water maintained at body temperature. Thus, smeared-on grease may help the troops' feet in Viet Nam, but it still isn't known why a soldier's feet get so sore when they get wet.

Authors of the report are Larry J. Buckels, M.D., of the Naval Medical Field Research Laboratory, Camp Lejeune, N.C.; Kenneth A. Gill, Jr., M.D., of the U.S. Naval Hospital, Camp Lejeune, and Gustave T. Anderson, M.D., Navy Department, Washington, D.C.

NEW JERSEY DOCTORS' NOTEBOOK

Jersey Medical History Wins Citation

The Healing Art, Bicentennial History of The Medical Society of New Jersey, was awarded a Certificate of Commendation at the 1967 annual meeting of The American Association for State and Local History. Meeting at Toronto, Canada, on September 1, the Committee on Awards of the Association granted the honor to Fred B. Rogers, M.D. and Mrs. Arlene Reasoner Sayre of Trenton, co-authors of the volume subtitled, *The Medical Society of New Jersey through two centuries — 1766-1966.*

The Certificate here reproduced was signed by American Association for State and Local History President Russell W. Fridley, Minnesota Historical Society, and Alexander J. Wall, Old Sturbridge Village, Massachusetts, Chairman on Awards.

Later, at the One Hundred and Twenty Second Annual Meeting of The New Jersey Historical Society at Newark on December 6, 1967, this Certificate was presented in person to Dr. Rogers and Mrs. Sayre by President John T. Cunningham, prominent writer on New Jersey and an advisor on production of *The Healing Art.*



The American Association for State and Local History

by a vote of its Committee on Awards presents a

CERTIFICATE OF COMMENDATION

to

The Healing Art, A History of the Medical Society of New Jersey
by Fred B. Rogers and Arlene Reasoner Sayre

awarded this first day of September, Nineteen Hundred and Sixty-seven

Russell W. Fridley
President

Alexander J. Wall
Chairman, Committee on Awards

Trustees' Minutes

December 17, 1967

A regular meeting of the Board of Trustees was held on December 17, 1967, at the Executive Office. For your further information, detailed minutes are on file with the Secretary of your county society. A summary of the significant actions follows:

Hospital Emergency Departments . . . Directed that the following opinion be supplied to the member of the Passaic County Medical Society who raised the question of corporate practice of medicine as it concerns full-time physicians in emergency rooms:

"As long as the medical care being rendered is by individual licensed physicians, whose medical services are individually compensated, there is no corporate practice of medicine involved."

New Jersey Hospital Association . . . Approved the Executive Director's acceptance of an invitation to attend meetings of Trustees of the New Jersey Hospital Association, as an *ex-officio* member, thus providing continuity in developing stronger relations between MSNJ and NJHA.

Medical Practice Act . . . Authorized the duplication of sufficient copies of a current "paste-up" version of the Medical Practice Act for distribution to the members of the Board, with a presentation copy for the Board of Medical Examiners.

Bicentennial Plaques . . . Empowered the Executive Director to arrange for the permanent installation of plaques commemorating bicentennial donors to the Medical Student Loan Fund, and directed that pictures of the plaques be sent to the donors.

Essex County Resolutions . . . Directed that two resolutions from the Essex County Medical Society *re* AMA releases (page 23, January JOURNAL) be referred to the Secretary for processing at the 1968 Annual Meeting, prior to being forwarded to the AMA House of Delegates in June.

Smoking on Hospital Premises . . . Agreed to support the recommendation of the New Jersey Hospital Association that *no form of tobacco should be sold in New Jersey hospitals.*

AMA Council on Medical Education . . . Approved the nomination of Dr. Joseph P. Donnelly for membership on the AMA Council on Medical Education, and directed that support of other delegations be solicted for this nomination.

New Jersey College of Medicine's Year Book . . . Authorized a contribution of $50 to the New Jersey College of Medicine's Year Book Fund.

Board of Medical Examiners . . . Directed that the following nominations (listed in the order of preference) be submitted to the Governor for consideration at the expiration of the term of Dr. Ralph M. L. Buchanan:

Ralph M. L. Buchanan, M.D., of Phillipsburg
Nicholas G. Demy, M.D., of Somerville
Raymond A. McCormack, M.D., of Trenton

Conference on Tax Problems . . . Authorized the attendance of two MSNJ staff members, with expenses paid, at the 4th Annual Conference on Federal Tax Problems of Non-Profit Organizations, to be held in Washington, D.C. on February 26th and 27th.

Robert M. Backes . . . Accepted with regret the resignation of Robert M. Backes, legal counsel for MSNJ, effective no later than June 1, 1968.

Theresa E. Goeke . . . Accepted with regret the resignation of Theresa E. Goeke, Executive Assistant, effective June 7, 1968.

Morris County Medical Society Resolutions . . . Received two resolutions from the Morris County Medical Society and directed that they be forwarded to the Secretary for processing for the 1968 Annual Meeting.

Communicable Diseases in New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of December.

	December 1967	*December 1966*
Aseptic meningitis	11	10
Encephalitis, primary	0	2
Encephalitis, post-infections	0	2
Hepatitis, total	130	78
Infectious & Unknown	113	61
Serum	17	17
Malaria (servicemen)	14	†21
Measles	95	183
Meningoccal meningitis	8	†11
Mumps	1,155	—
Rocky Mountain Spotted Fever	0	†1
Primary Syphilis	48	†55
Salmonella	54	44
Shigella	15	†7

Influenza

Influenza came a month early to New Jersey as it did to much of the United States. The first areas to report increased school absenteeism were in Bergen County. That was during the week of December 3. Ten days later, increased absenteeisms were reported in Passaic, Monmouth, Middlesex, Morris, Essex, and Union Counties. *In toto,* thirty-five schools reported absenteeism of greater than twenty per cent. Most of the absenteeism was due to an influenza-like illness. High schools were affected more than the lower grades. Calls to scattered industries in New Jersey also revealed increased absenteeism due to this illness.

In your State Health Department, the Division of Preventable Diseases has a surveillance system set up with the school system, with certain large industries, and with the state institutions. Increased absenteeism or sickness (possibly due to influenza) is reported to the State Health Department. For individual cases, influenza is *not* a reportable disease.

Here is how you get a laboratory confirmation of influenza in a school. Blood for hemagglutination inhibition (H. I.) tests and complement fixation (C. F.) tests is drawn on about six individuals who have symptoms which are representative of the illness the school population is currently experiencing. Two weeks later convalescent blood is drawn on these individuals to see if they have a rise in titer of H. I. and C. F. influenza antibodies. If these people show a rise in titer, the assumption is made that it was an outbreak of influenza. To make a more rapid serologic confirmation of influenza, blood is drawn on several children who are apparently "coming down" with the illness and also on those who had the same symptoms 7 to 10 days before. If the latter group has significantly higher titers than the former, it would be assumed (but less assuredly) that the outbreak was due to influenza. Virus isolation is made from throat washings which are taken in those who have had the disease for 48 hours or less. Through virus isolation one can tell whether the virus is similar to that used in the vaccine. As of December 29, 1967, there has been no virus isolated in New Jersey.

Measles

Measles continue to exist in New Jersey and thirty-nine cases were reported for the week ending Friday, December 22. Most came from the metropolitan areas: Newark, Paterson, and Trenton. All the cases have been in unimmunized children. In New Jersey, not a single confirmed case of measles has occured in a child immunized on the live measles vaccine. Due to the declining incidence of measles, we now feel that each case should be investigated to see whether there is a susceptible population. If such is the case a measles immunization program can be instituted to thwart a possible outbreak. Programs are now being considered in localities where measles persist.

In July, the New Jersey Legislature passed A-480 which states that, "The Board of Education of any school district may require all pupils to have received immunizing treatment against poliomyelitis or measles, or both, as a prerequisite to attendance at school; and it may at its discretion require or waive proof of immunity, except as hereinafter provided."

†This figure is approximated for the total number of cases reported in 1966.

Mumps

Approximately 200 cases of mumps are reported weekly. An analysis of 500 cases shows a relatively equal number of males and females. The greatest number of cases is in the 5 to 9 age group. The Division of Preventable Diseases is interested in obtaining information on the incidence of mumps so that we will be able to evaluate the effects of the forthcoming live mumps vaccine.

Malaria

(This material is from Morbidity and Mortality Weekly Review, Dec. 15, 1967.)

Epidemiologic information was received on 2,303 cases of malaria with onset in the United States from January 1 to November 15, 1967, by the Malaria Surveillance Unit. Of these 2,174 cases were in servicemen who had acquired infection in Viet Nam. Only seven of the 2,303 cases acquired infection in the United States; three blood transfusion induced cases; two introduced cases; one cryptic case; and one congenital infection.

The Plasmodium species was identified in 97 per cent of all cases.

A Few Kind Words For Hunting

The following is a letter written by one of our members, John Douglas Preece of Trenton, to the members of the Hunting Valley Hunt in Pennsylvania, of which he is the current president.

The slanting rays of the sun and the shortened daylight hours indicate that the year's end is near. The migrant birds have flown. The easy living months are gone.

Man, early in history, learned that he must harvest and store for survival through the cold and dormant season of the year. Later he learned that he must also protect his spirit through the cheerless season, when beauty has flown from the countryside, for this is the season of sadness, ennui, and despair.

God in His great goodness endowed man with the ability to adapt to his environment and to compensate for his losses. To offset the cheerless days of Fall, He gave to man the gift of Hunting. He has set the gray skies of November as a backdrop for the red hunting coat. He has sent the Fall rains to soften the earth for the hoofs of the horse. Each night He sets a heavy dew to hold the scent for the hounds.

To you, who long for the lost color of the summer as you look at the cheerless hills with leafless trees pointing their bare branches skyward, look again when you hear the music of the hounds and watch how the picture changes with the appearance of a red-coated huntsman and his pack of hounds winding down through these same trees.

Is anything more forbidding to the eye than the November cornfield with the stalks crumpled in grotesque patterns over the dark clods? But see it now with a pack of hounds, noses to earth, tails gaily flagging, crossing at a gallop followed by red-coated horsemen, with the sound of hunting horn and hound music in the air.

It is noteworthy that when man has learned to compensate in his life, the compensatory action sometimes exceeds all expectations and supersedes what was formerly the primary motivation of his being.

Fox-hunting has been known to do just this and to end up taking more of man's time than his business. But there comes a time in life when this is right and good. For business, by its definition, is an activity to provide for the necessities of life. Men have been known to forget this fact and make business their whole life, and with this comes frustration, gastric ulcers, and cardiac attacks. Fox-hunting takes man back to Nature and Nature takes man back to God.

So . . . toll not the bell for the passing of Summer, but ring in joyously the advent of the Season for Hunting. For Hunting can prolong your life; and save your soul.

AMA Delegates' Actions

The AMA House of Delegates met in Houston in November 1967. Here is a brief summary of some of its actions. This is, of course, not a report from the delegates; it is simply items culled from AMA releases and published for the information of our readers.

AMA-ERF Institute for Biomedical Research . . . Approved in principle the relocation of the Institute for Biomedical Research "on or contiguous to the University of Chicago." The House asked the Board of AMA-ERF "to present at each Clinical Convention a report on the projected budget of the Institute for Biomedical Research for the ensuing year and the amount of the projected contribution from the American Medical Association during that period."

Medical Education . . . Adopted the Board of Trustees' summary of the Report of the Commission on Research. This included two significant recommendations: (1) To encourage research in the delivery of health care, "provided it is conducted under proper auspices and in accordance with sound research design and methodology." This is not intended as criticism of the present studies of the delivery of health care, but indicates the medical profession's interest in continued studies to improve methods. (2) To correct the imbalance between biomedical research and education caused by the "heavy but desirable federal support of research," pointing out that there should be allotted "a greatly increased amount for operational expenses of medical schools, to be matched by those schools through private or local governmental sources." This changes the AMA policy with respect to federal support for medical education, and is "an honest recognition that federal financial support is now accepted by the American medical schools. However, the AMA emphatically urges that a matching formula be used to "encourage medical schools to retain their independence."

. . . Urged the AMA, through its Council on Medical Education, to "utilize all appropriate influences to restore teaching to its proper place in medical education," instead of giving the lion's share to research scientists.

Manpower . . . Adopted the preliminary report on the "Report of the National Advisory Commission on Health Manpower," which was submitted to President Johnson on November 20. This indicated that in the approach to health care problems there was recognition of the need for orderly procedure rather than "crash" programs. Emphasis should center on the professional groups best able to evaluate and plan in health areas, rather than on government and non-professionals.

. . . Approved replacing the AMA Commission to Coordinate the Raltionships of Medicine with Allied Health Professions and Services with a new council of the Board of Trustees, to be known as the Council on Allied Health Professions.

. . . Directed the AMA to seek the establishment of a medically oriented federal Commission on Health Resources and Medical Manpower to assure properly balanced distribution of health personnel among government agencies, the armed forces, and the civilian population.

Health Care . . . Adopted the following relating to health care:

1. Emphasizes that standards of medical care are set at the local level and points out the trend to establish national standards.

2. Commits the AMA to leadership in informing the public, the profession, and allied fields as to means of moderating health care costs, the value of voluntary health insurance, expanding medical manpower, and improving health care.

3. Urges state and local medical societies to emphasize activities in the area of planning for governmental and private programs of health care, including efforts to improve federal legislation in this area.

4. Urges support of legislative action to implement the concept that the procurement, processing, and distribution and use of human blood (and other human tissue) are medical services and not the selling of a commodity.

5. Supports the use of monitoring, defibrillation and resuscitative equipment by registered nurses in cardiac emergencies in accordance with established procedures of the hospital.

6. Identifies alcoholism as a complex disease and recognizes that the medical components of this entity are medicine's responsibility.

Medicare and Medicaid . . . Reaffirmed its support for the direct billing of medicare patients and adopted a resolution concerning the public dissemination of figures on the administrative costs of Medicare.

. . . Urged continuation of AMA efforts to provide for the implementation of Title 19 in a manner which recognizes the physician's right to bill directly; and urges reimbursement at usual, customary, and reasonable fees.

Legislative Matters . . . Adopted recommendations that the AMA arrange a meeting of state medical association representatives to plan a regional conference of physicians to discuss matters of special interest to state legislators; and asks state medical societies to invite key lawmakers to attend these conferences.

. . . Approved a resolution that state medical societies establish active legislative task forces at the congressional district level.

. . . Reaffirmed its support of AMPAC and requested the AMA Trustees to seek additional ways to expand its activities.

Hospitals . . .Directed that the AMA study payment to residents for services to Medicare and Medical patients.

. . . Asked for the development of guidelines acceptable to supervising physicians, teaching institutions, and government agencies.

. . . Adopted the following resolutions with respect to hospitals:

1. Proposed the selection of physicians to sit on hospital Boards of Trustees as the most effective form of liaison between the medical staff and governing body.

2. Called for protection of hospital privileges through "due process."

3. Called for more effective liaison between medical staffs and local medical societies.

4. Urged simplifying attendance requirements for membership on hospital staffs.

5. Pressed for revision of the JCAH ruling on externs in non-university hospitals and incorporation of safeguards to insure quality extern education.

Changes in Bylaws . . .

1. Four trustees will be elected annually, each for a three-year term, and each limited to three terms.

2. Terms of President, President-Elect, and Vice President will begin and end at the close of the final session of the House at the Annual Convention.

3. Resolutions must be introduced by a voting delegate.

4. An officer's position is to be considered vacant if he misses six consecutive regular meetings of the Board.

5. The Vice-President was given voting rights on the Board.

AMA Objectives . . . Adopted a statement of:

1. Encourage the further development of medical knowledge, skills, technics, and drugs; and maintain the highest standards of practice and health care.

2. Create incentives to attract increasing numbers of capable people into medicine and other health-care professions.

3. Advance and expand education of physicians and others in the health-care field.

4. Motivate physicians skilled in teaching to apply themselves to developing new generations of excellent practitioners.

5. Foster programs that will encourage medical and health personnel to serve voluntarily in the areas of need for medical care.

6. Develop technics and practices that will moderate the cost of good medical and health care.

7. Seek out means of making all health care facilities — pyhsicians' offices, hospitals, laboratories, clinics, and others — as efficient and economical as good medical practice and attention to human values will permit.

8. Combine the utilization of the latest knowledge for prevention and treatment with the vital healing force of the physician's personal knowledge of and devotion to his patient.

9. Maintain the impetus of dedicated men and women in providing excellent health care by preserving the incentives and effectiveness of unshackled medical practice.

10. Maintain the highest level of ethics and professional standards among all members of the medical profession.

11. Continue to provide leadership and guidance to the medical profession of the world in meeting the health needs of changing populations.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

GENERAL—Loren T. Burns, M.D., 7 West 14th Street, New York 10011. University of Illinois, 1967. Available July 1968.

Lloyd O. Long, M.D., 337 East Main Street, Newark, Delaware 19711. Indiana University, 1963. Available January, 1968.

INTERNAL MEDICINE—Harvey I. Hurwitz, M.D., 33 Coleman Road, West Haven, Connecticut 06516. Boston University, 1962. Group. Available July 1968.

Alfred M. Derrow, M.D., 555 Wisteria Way, San Rafael, California 94903. Tufts 1962. Subspecialty, Renal Disease. Group. Available July 1968.

Seymour M. Cohen, M.D., 1565-A White Drive, Rantour, Illinois 61866. University of Pittsburgh, 1962. Board eligible. Subspecialty, Hematology. Group or partnership. Available July 1968.

George G. Shashaty, M.D., 287 Linden Boulevard, Brooklyn, New York 11226. Georgetown University, 1962. Subspecialty, Hematology. Group or partnership. Available July 1968.

Harry M. Friedland, M.D., 2329 South Cedarbrook Road, Springfield, Missouri 65804. Downstate Medical Center (NYU), 1961. Subspecialty, Gastroenterology. Available July 1968.

Richard Kroner, M.D., 3750 Hudson Manor Terrace, Riverdale, New York 10463. New York Medical, 1964. Group. Available July 1968.

Edgar Lichstein, M.D., 1777-F Arlin Village Place, Fairborn, Ohio 45324. Downstate Medical Center (NYU), 1961. Board eligible. Subspecialty, cardiology. Available July 1968.

OBSTETRICS AND GYNECOLOGY — David M. Margulies, M.D. 69 Euclid Road, Fort Lee, New Jersey. Northwestern Universty, 1961. Board certified. Available.

Arthur G. Aneckstein, M.D., 104A Jupiter Street, Sheppard AFB, Texas 76311. Tulane, 1961. Board eligible. Solo, partnership, or association. Available February 1968.

Kenneth E. Bell, M.D., 3175 B Lexington Street, Hill Air Force Base, Utah 84401. University of Buffalo, 1961. Board certified. Available June 1968.

Jerry Goosenberg, M.D., 75-B Yorktown Drive, Fort Lee, Virginia 23801. Jefferson, 1962. Board certified. Group. Available July 1968.

Arnold J. Halpern, M.D., 516 Almond Court, Hampton, Virginia 23369. Jefferson, 1959. Board certified. Available June 1968.

OPHTHALMOLOGY—Harold J. Goldfarb, M.D., EENT Clinic, Womack Army Hospital, Fort Bragg, North Carolina 28307. Tufts, 1961. Board certified. Solo or associate in northern New Jersey. Available March 1968.

PEDIATRICS—Nathan Blinn, M.D., 1514 East Cliveden Street, Philadelphia, Pennsylvania. Jefferson, 1963. Solo or group. Avaliable July 1968.

James Sorger, M.D., 27 Warner Arms, Warner Robins, Georgia 31093, NYU Medical, 1963. Board eligible. Solo, group, partnership, or association. Available July 1968.

SURGERY — Dennis M. Wadler, M.D., 245 East 25th Street, New York 10010. Jefferson, 1961. Board eligible. Associate or group. Available July 1968.

Morton H. Goldstein, M.D., 3411 Wayne Avenue, Bronx, New York 10467. University of Chicago, 1959. Board certified. Plastic. Available summer 1968.

Martin Winick, M.D., 800 Victory Boulevard, Staten Island, New York, Downstate Medical Center (NYU), 1960. Board certified. Pediatric. Available July 1968.

Donald A. Sugar, M.D., 5 Wheeler Place, Fort Stewart, Georgia 31313. New York Medical, 1961. Board — part I. Group or solo. Available May 1968.

Robert Wegryn, M.D. St. Mary's Hospital, 89 Genesee Street, Rochester, New York 14611. Cornell, 1963. Board qualified. Group or partnership. Available August 1968.

UROLOGY—Alessandro Colalillo, M.D., 570 Mt. Prospect Avenue, Newark, New Jersey. University of Naples, Italy, 1955. Partnership or association with multispecialty group. Available.

Raymond D. Panetta, M.D., 632 Massachusetts Avenue, Riverside, California 92507. Georgetown, 1959. Board eligible. Group, partnership, or solo. Available June 1968

1968 Annual Meeting

Saturday, Sunday, Monday, Tuesday, Wednesday May 18-22, 1968

Haddon Hall, Atlantic City

Heart Transplantation— In The Cards

Not knowing that a South African surgeon was waiting in the wings, Dr. Norman Shumway suggested that we were about ready to try human heart transplantation. An interview with Dr. Shumway appeared in the November 20, 1967 JAMA.

"One person's heart will be transplanted to another's body as soon as a suitable donor and recipient can be found," said Dr. Shumway, head of Cardiovascular Surgery at Stanford Medical Center, Palo Alto. "We have achieved a degree of experience with (animal) heart transplantation in the laboratory which makes us confident we can take appropriate care of the patient with a cardiac transplant."

The most likely candidate to receive a heart would be a patient whose own heart cannot be restored to normal pulse when taken off a heart-lung machine during open-heart surgery. Other possible recipients being considered at Stanford are children born with heart defects for which there is no corrective surgery or treatment. An infant with tricuspid atresia would be a possible recipient.

The ideal heart donor would be a relatively young person dying of causes unconnected with heart disease. Thus far, the ideal donor and ideal recipient have not coincided at the Stanford Medical Center, although patients of both types have been treated there recently.

Dr. Shumway stressed that animal experimentation should and will continue, but "we are nonetheless at the threshold of application" of heart transplant to humans. If the heart can be removed from the donor within a half-hour after death, it can be resuscitated without suffering damage from oxygen lack. This time span can be lengthened somewhat by immersing the heart in cold salt-water solution. The important factor is not so much the overall time of oxygen lack, but the period of oxygen shortage at body temperature. "This is what is damaging to the heart — the period of normal temperature during which there isn't any circulation in the coronary arteries." Further, it may be possible to maintain a heart for short periods by cross-circulation with a third patient or with a heart-lung machine. "But at the moment, we are depending upon the coincident situation in which the donor and recipient are immediately available." This means that as long as heart transplantation is confined to emergency situations, its use will depend upon the chance availability of a suitable donor heart at the time of need.

Heart transplantation thus is not likely to achieve widespread use until (1) methods are found for preserving the heart or (2) further experience allows surgeons to transplant hearts as elective surgery when donors are available. The surgical technic of transplantation has been well worked out in the laboratory. Technical difficulties are not expected in the first human transplant. Indeed, transplantation in the human probably will be less difficult than in the dog, because a dog's aorta is unusually fragile.

Immune reactions are the body's defense against foreign bodies, a major problem of any organ transplant. This will be the same for a transplanted heart as for transplanted kidneys. However, laboratory experience suggests that a heart-transplant patient might not be able to tolerate the high drug dosages sometimes administered to suppress immune reactions.

Dr. Shumway does not anticipate social or legal difficulties in cardiac transplantation, although these may restrict use of the method in some areas. And there are emotional and subjective attitudes about the heart that don't apply to transplanted kidneys or livers, Dr. Shumway pointed out.

The period between death and heart removal is the time when irreversible brain damage sets in. Thus, "removal of the heart cannot be objected to on the grounds that if it can be resuscitated outside the donor's body there existed the possibility that the donor himself could have been revived."

Special Psychiatric Lectures

You are welcome to attend lectures in New York City on the topics indicated below. All meetings start promptly at 8 p.m. at the Postgraduate Center for Mental Health which is at 128 East 28th Street. This series is jointly sponsored by the Center and the Hoffman LaRoche Foundation. As you see, these are somewhat off-trail subjects, not found in the conventional texts or lecture series. The Postgraduate Center for Mental Health operates in four areas: it provides treatment for those unable to pay private psychiatric fees; comprehensive training for psychiatrists; research projects; and community mental health services. Here is the 1968 schedule of lectures:

February 29 — S. Bogoch, M.D., Professor of Biochemistry at Boston University, "Biochemical Research and Its Implications in Clinical Practice."

March 14 — B. Pfeffer, M.D., director, Clinic for Children and Adolescents, Postgraduate Center for Mental Health, "Problem Groups in Practice: Children and Adolescents."

March 28 — L. R. Wolberg, M.D., dean, Postgraduate Center for Mental Health, "New Brief Directive Therapies."

April 11 — L. B. Bellak, M.D., clinical professor of psychiatry, New York University, "Emergency Psychiatric Situations."

April 25 — H. B. Esecover, M.D, director of residency training at Hillside Hospital, "Psychedelics."

May 9 — D. W. Hastings, M.D., professor of psychiatry, University of Minnesota: "Brief Technics in the Treatment of Sexual Problems."

May 23 — G. Balliett, and F. U. Tate, M.D. (chief psychiatry), American Foundation of Religion and Psychiatry, "Management and Economics of a Psychiatric Practice."

Our New Narcotic Law

On December 29, 1967, Governor Hughes signed into law A-547, which amended 314 PL 1966. A digest follows. This material was sent to all physicians and pharmacies in New Jersey. If you discarded it, and do not bind your JOURNALS, clip this material and save it. Or you can get full copies from the Drug Control Coordinator, Box 1540, Trenton, 08625 (Attention, Mr. R. J. Russo). Or, if you have any questions, phone (609) 292-5595.

The new law established categories of Class "A," "B," "X," and "M" narcotic drugs identical with those of the Federal Narcotic Law.

1. Class "A" narcotic drugs are under full control requiring a prescription signed by the practitioner *prior to delivery of the drug.*

2. Class "B" narcotic drugs may be dispensed by a pharmacist upon the oral prescription of a practitioner. Signature of the practitioner is *not* required for the Class "B" narcotic oral prescription.

3. Class "X" narcotic drugs cannot be sold to persons under 21 years of age except on prescription. Those persons 21 years of age and older can purchase a Class "X" narcotic drug over-the-counter as heretofore. However, an over-the-counter sale to any individual of more than 4 ounces of any Class "X" narcotic drug in any one 24 hour period is a violation under this law.

Paregoric U.S.P. is an "X" narcotic drug. However it must be dispensed by prescription only, except when sold or dispensed in compounds containing not more than 1 fluid drachm of Paregoric in each fluid ounce of a medicinal preparation.

Depressant and Stimulant Drug Law

This law, which is similar to the Federal Drug Abuse Amendments commonly referred to as HR-2, provides for stronger regulations of depressant and stimulant drugs, and all pharmacies, hospitals, clinics, and *dispensing physicians* must prepare an initial inventory and keep a record of receipt and disposition of controlled drugs. A dispensing physician is a practitioner who regularly engages in dispensing any depressant or stimulant drug to his

patients for which they are charged either separately or together with charges for other professional services.

All controlled drugs dispensed by a pharmacist are subject to the "five time renewal limit" and the "six month prescription expiration limit." Renewal of any controlled drug prescription beyond these limits, requires that the practitioner issue the renewal either in writing or orally to the dispensing pharmacist.

The State Health Department has prepared a list of all the drugs controlled under this law. This list, includes approximately *1300* drugs. Each pharmacy in New Jersey has a complete list of these drugs.

Narcotic Drug Classification Sheet

CLASS A

Alphaprodine[a]	Ethylmorphine	Opium
Anileridine	Hydrocodone	Oxycodone
Cocaine	Hydromorphone	Oxymorphone
Codeine	Levorphanol	Pethidine (Meperidine)
Dihydrocodeine (Parzone)	Methadone	Phenazocine
Diphenoxylate	Morphine	Phocodine
		Piminodine

CLASS B

	Maximum Amount of Narcotic or its Salt Allowable for Oral Prescription[b]							
	With No Other Active Ingredient	With a Benzylisoquinoline Alkaloid				With a Therapeutic Amount of a Non-Narcotic Drug			
		per dosage unit		per fl. oz.		per dosage unit		per fl. oz.	
		mg.	gr.	mg.	gr.	mg.	gr.	mg.	gr.
Codeine	0	64.8[c]	1[c]	518.4	8[c]	64.8	1	518.4	8
Dihydrocodeine (Parzone)	0	0	0	0	0	64.8	1	518.4	8
Hydrocodone	0	10.8[d]	1/6[d]	86.4[d]	1 1/3[d]	10.8	1/6	86.4	1 1/3
Ethylmorphine	0	0	0	0	0	10.8	1/6	86.4	1 1/3
Apomorphine	therapeutic quantity	therapeutic quantity		therapeutic quantity		therapeutic quantity		therapeutic quantity	
Noscapine	therapeutic quantity	therapeutic quantity		therapeutic quantity		see class M		see class M	
Papaverine	therapeutic quantity	therapeutic quantity		therapeutic quantity		see class M		see class M	

CLASS X

Maximum Amount of Narcotic or its Salt per fl. oz. or 28.3 Gms.

	mg.	gr.
Codeine	64.8	1
Dihydrocodeine	32.4	1/2
Ethylmorphine	16.2	1/4
Morphine	16.2	1/4
Opium	129.6	2
Diphenoxylate	—[e]	—[e]

CLASS M

Narcotic content of the formulation not limited in amount.

Noscapine
Papaverine
Narceine
Catarnine
Nalorphine

[a] This list includes only those narcotic drugs in common medicinal use.
[b] In pre-manufactured remedies, proprietary preparations or extemporaneous prescriptions.
[c] The ratio of benzylisoquinoline alkaloid to codeine must be at least 1:1.
[d] The ratio of benzylisoquinoline alkaloid to dihydrocodeinone must be at least 4:1.
[e] Pharmaceutical preparations containing not more than 2.5 mg. diphenoxylate and not less than 25 micrograms atropine sulfate per dosage unit.

Want To Render Service Abroad—At Your Own Expense?

AmDoc is an organization that will get you to Asia, the Far East, Africa, or Central America. AmDoc receives applications from physicians, dentists, and allied health professionals. The applicants are willing to serve without salary — indeed at their own expense. Why would anyone do that? Well, their motivation may be a desire for broader experience or for giving of themselves, or both. It can be a challenging, rewarding, and exhilarating experience. It is also fun. AmDoc encourages family participation as a means of education in basic international human understanding. AmDoc assignments are acceptable for educational credit by the American Academy of General Practice.

AmDoc's boards serve without compensation. The members of AmDoc's Operating Board are: President: William B. Van Valin, M.D.; Vice-President: Melvin A. Casberg, M.D.; Director: E. Croft Long, M.B., B.S., Ph.D.; Director: Tad Lonergan, M.D.; Secretary-Treasurer: Mrs. Elizabeth Zimdin. Its Advisory Board consists of: Roy W. Day, M.D., Joseph M. de los Reyes, M.D., William J. DeMaria, M.D., Rudolph E. Drosd, M.D., F.A.C.S., Omar J. Fareed, M.D., G. Peter Nagel, M.D., and Henry M. Stern, M.D. The Working Board, composed of thirty-one doctors who have served one or more AmDoc assignments, advise doctors going to locations in their world area of service.

Ask Dennis G. Karzag, Executive Secretary of AmDoc, 27 East Canon Perdido Street, Santa Barbara, California 93101, for more details and a copy of AmDoc's publication which informs its readers of current programs and reports of physicians returning from abroad.

AmDoc has some 70 doctors at work in a dozen countries. Paul Williamson, M.D., medical writer who played a key role in AmDoc's founding about two years ago, is in Eket, Nigeria, and AmDoc president David P. Hansford, M.D., is in Monrovia, Liberia.

Of the AmDoc-Direct Relief Foundation working arrangement, Karzag writes:

"One of the strangest marriages in charity medicine has turned out to be one of the most successful.

"The Direct Relief Foundation, an organization designed to move charity drugs overseas, is old and venerable. For 18 years it has been doing its job of sending supplies from Santa Barbara, Calif., all over the world.

"By contrast," continues Dr. Karzag, "AmDoc is an upstart. It is only four years old and depends largely for its support on doctors, though an increasingly larger number of business men are getting interested, and it is not affiliated with any one group or the government." It (the working arrangement) simply gives us both facilities that we have not had before. Now we are prepared to send drugs, equipment, and doctors anywhere.

"You have no idea how frustrating it is to send only part of what a hospital needs. For years, we have been furnishing drugs. For years, appeals would come in — 'Send us more doctors' — but we had no way to do so. AmDoc has had the same thing. The doctor would be placed in the field, but he would not have the drugs."

AmDoc was incorporated in March 1964 in Illinois and administered initially by executives of the Christian Medical Society. In December 1964, there was a reorganization of its Board of Directors, and its headquarters were moved to Texas and then California.

Its budget is about $35,000 per year, and Dr. Williamson writes a twice-monthly journal-newsletter. It expresses a desire not to be associated with anything which would give it a label, such as religious or governmental.

The physician is asked to pay all transportation costs for himself and family to and from the field of service. The sponsoring organizations — and AmDoc's purpose is to put physicians in touch with those needing them—are expected where possible to provide room and

board for the doctor and his family while he is in the field.

Direct Relief Foundation's operating budget is about $200,000 annually. It was founded in 1948 by the late William Zimdin, who was born in Estonia and lived under Nazism and Communism before coming to the United States. Overhead is said to be about 2½ per cent. Woman's auxiliaries to medical societies are among supporters.

Pains That "Run In The Family"

In some families, every member seems to have a headache, or nausea, or insomnia, or an assortment of vague aches and pains. Physicians have long marked off such complaints to "nervousness" because there never seemed to be a more specific cause. These symptoms may be related, however, and they may be inherited, suggests a report in the *Journal of the American Medical Association,* July 10, 1967.

In addition, members of such families may have distinct personality patterns. Many seem to have been shy in childhood, and to have suffered from motion sickness. As adults, these persons tend to be ambitious perfectionists, rather rigid in their outlook, and often suffer peptic ulcers and migraine headaches. Eventually, the report suggests, they may "outgrow" many of these symptoms.

When he questioned 100 patients who had Heberden's nodes, William K. Ishmael, M.D., of Oklahoma City, found that 52 also suffered migraine headaches; 76 averaged less than six hours' sleep a night; 73 suffered painful shoulder joints, and 67 per cent had had childhood motion sickness. Members of the patients' immediate families reported similar percentages of these complaints (and 58 per cent of these relatives also had the finger and toe-joint nodes). A second group of 100 patients and their families reported similar symptoms.

When Dr. Ishmael questioned 100 persons over age 50 who did *not* have Heberden's nodes, he found that far fewer reported migraine headaches, only 12 per cent had suffered motion sickness as children, only 11 per cent had peptic ulcer, and more than 93 per cent said they slept well, getting more than six hours' sleep a night.

Dr. Ishmael says that migraine and Heberden's nodes—a sign of osteoarthritis—may be clues in understanding some patients' frequent feelings of ill health. The person with primary osteoarthritis is likely to have a predictable life's story, Dr. Ishmael said.

"In childhood there are apt to be personality characteristics of shyness, and inflexibility, and a tendency for clinical nausea or motion sickness and a light sleeping pattern. This gives rise to adult perfectionism, migraines, and periods of nausea and peptic symptoms. Characteristics of rigidity, hypersensitivity, resentment, ambitiousness, and efficiency are predictably present.

"Persons with these characteristics are frequently light sleepers, impatient with themselves, and usually have an overdose of will or a tendency to drive themselves. This trait, coupled with the osteoarthritis results in periodic episodes of pain and disability in the neck, low back, fingers, and knees, with significant morning stiffness.

"These patients have an unusual state of awareness and a constitutional predisposition to sustained emotional stress which may be expressed as anxiety, irritability, depression, an impaired capacity to sleep, headaches, and face pain. In general, they are overly motivated, and become upset if they fall short of their goals."

These characteristics are present so often in the osteoarthritis victim and his family that they may be considered as physiologic in origin as well as psychologic, Dr. Ishmael suggests. They may also be inherited, he thinks.

ANNOUNCEMENTS

Occupational Medicine Institute

Columbia University School of Public Health and Administrative Medicine announces the eleventh annual Institute for Physicians in Industry. The one week course will be held at the Columbia-Presbyterian Medical Center in New York City, March 4 to 8, 1968.

The Institute is an intensive refresher course for physicians practicing in the field of occupational medicine. In addition, several sessions will be devoted to basic public health subjects. Physicians preparing to take specialty board examinations should find this institute particularly useful.

Further information and applications may be obtained from the Program of Continuing Education, Suite 305, at 21 Audubon Avenue, New York 10032. The telephone is (212) 568-4334.

The Eye and The Orbit

At the Eye and Ear Infirmary, 218 Second Avenue, New York City 10003, the distinguished Swiss ophthalmologist, Alfred Huber of Zurich, will deliver five lectures in English from March 25 through 29, 1968.

Monday, March 25, 1968 Papilledema: Diagnosis and Differential Diagnosis	3-6 p.m.
Tuesday, March 26, 1968 Angiography and Phlebography of the Orbit	3-6 p.m.
Wednesday, March 27, 1968 X-ray Pathology of the Orbit	3-6 p.m.
Thursday, March 28, 1968 Visual Field Alterations in Brain Tumors	3-6 p.m.
Friday, March 29, 1968 Secondary Glaucoma	3-6 p.m.

All lectures will be augmented by audio-visual material. A question and answer period will be held at the conclusion of each. The fee is $20 per lecture. For registration, please send check (specifying which lectures) to the Registrar, Institute of Ophthalmology, Eye and Ear Infirmary, 218 Second Avenue, New York 10003.

EENT Clinical Conference

April 1 and 2 are the dates and New York's Hotel Biltmore is the place for the ever-popular clinical conference of the New York Eye and Ear Infirmary. The ophthalmology program will include a candid review of controversial methods of cataract extraction; papers on diabetes; muscle surgery; glaucoma; ocular trauma; aphakic detachment; and war injuries.

The otolaryngology session will hear papers by Howard House, M.D.; John Lindsay, M.D.; J. H. Rambo, M.D.; John Cinelli, M.D.; John Daly, M.D., and Maurice Miller, Ph.D.

For details, write to the Registrar, Eye and Ear Infirmary, 218 Second Avenue, New York, New York 10003.

Contact Lens Course

An advanced course in contact lens technology is announced by the New York Eye and Ear Infirmary for May 1968. This will be held on Sunday, May 19, 1968 at the Gramercy Park Hotel which is where 21st Street, New York City, crosses Lexington Avenue. In this program, special attention will be paid to detrimental effects on the cornea, to the problem of contact lenses for children, to the development and control of keratoconus, and to clinical problems in optics. The primary appeal of this course will be to ophthalmologists, but pediatricians will find much of interest in the discussion of contact lenses for children — even, indeed for infants. The fee is $50, but it is well worth it.

Luncheon is included without extra charge. For a specific time-table, for registration, and more information, write to: Registrar, Institute of Ophthalmology, Eye and Ear Infirmary, 218 Second Avenue, New York, New York 10003.

Honolulu In 1969

Don't look at your 1969 appointment book yet, but here is a chance to visit Hawaii in the course of the pursuit of knowledge. The American College of Surgeons convenes in San Francisco October 6 to 10 in 1969. And On October 14 there will be a meeting in Honolulu which you (even if you are not a FACS) may attend.

The scientific program will include 300 speakers in most surgical specialties. Concurrent meetings will be held on colon and rectal surgery, general surgery, neurosurgery, obstetrics, gynecology, thoracic-cardiovascular surgery, urology, anesthesiology, and radiology. All scientific meetings will be held in the morning, leaving afternoons free for sightseeing and social events.

Bring your family to take advantage of this combined scientific meeting and family holiday. If 1969 comes and goes without your making this trip, don't say we didn't warn you.

Your TV or Radio Appearance

Should a physician inform his county medical society of his appearance on a radio or TV program? How can a county society improve press relations through their physicians?

"Guidelines for Physicians In Their Relations With The Communications Media" offers practical suggestions for physicians regarding speaking engagements, photographs, the M.D.-patient relationship, and radio and TV appearances. This seven-page booklet, published by the AMA's Judicial Council, is available without charge from the Department of Medical Ethics.

202nd ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY

May 18-22, 1968

Haddon Hall, Atlantic City

Program Outline

Friday, May 17, 1968

4:00 p.m. — Board of Trustees
7:00 p.m. — Cocktails and Buffet-Dinner

Saturday, May 18, 1968

All Day — Installation of Exhibits
10:00 a.m. — Registration Opens
1:00 p.m. — Golden Merit Award Ceremony followed by Reception for GMA Recipients and their families
3:00 p.m. — House of Delegates and President's Farewell Address
4:30 p.m. — Nominating Committee
7:00 p.m. — Officers' Dinner

Sunday, May 19, 1968

9:00 a.m. — Registration Opens
9:30 a.m. — Special Scientific Sessions
10:00 a.m. — Coffee-meeting with Reference Committee Chairmen
10:45 a.m. — Reference Committees
12:00 noon — Exhibits Open
3:15 p.m. — House of Delegates (election)
4:00 p.m. — Inauguration of Incoming President followed by General Session
6:00 p.m. — Inaugural Reception
8:00 p.m. — Inaugural Dinner

Monday, May 20, 1968

9:00 a.m. — Registration and Exhibits Open
All Day — Scientific Sessions (MSNJ)
7:00 p.m. — Annual Dinner-Dance

Tuesday, May 21, 1968

9:00 a.m. — Registration and Exhibits Open
9:30 a.m. — House of Delegates
2:00 p.m. — Scientific Sessions (MSNJ)
7:00 p.m. — Exhibitors' Reception-Buffet Dinner

Wednesday, May 22, 1968

9:00 a.m. — Registration and Exhibits Open
9:00 a.m. — Board of Trustees
9:30 a.m. — Scientific Sessions (MSNJ/Special)
12:00 noon — Exhibits and Convention Close

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1968

February

13 **Bergen County Medical Society**

13 **Cumberland County Medical Society**

13 **The Academy of Medicine of New Jersey**
Section on Dermatology and New Jersey Dermatological Society
Englewood Hospital
"Dermatologic Parasitology"

14 **Gloucester County Tuberculosis and Health Association**

14 **Ocean County Medical Society**

14 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Somatic Aspects of Depression"

14 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Portal Hypertension: Physiology and Treatment"

15 **Morris County Medical Society**

15 **Gloucester County Medical Society**

16 **Cooper Hospital**
Camden
"Chemotherapy of Primary and Metastatic Malignancies"

19 **St. Barnabas Medical Center Department of Anesthesiology**
Livingston
"Pre- and Postoperative Digitalization and Diagnosis of Heart Failure in Surgical Patients"

19 **Newark Beth Israel Hospital**
Newark
"What's New in Pediatric Surgery"

20 **Warren County Medical Society**

20 **The Academy of Medicine of New Jersey, Section on Experimental Medicine**
Overlook Hospital, Summit

21 **Middlesex County Medical Society**

21 **The Academy of Medicine of New Jersey**
Robert Treat Hotel, Newark
Symposium on Pediatric Surgery

23 **Cooper Hospital**
Camden
"Neurological Aspects of Head Injuries"

23 **Industrial Medical Association of New Jersey**
Esso Research Laboratories, Linden

28 **The Academy of Medicine of New Jersey**
Princeton Hospital, Princeton
Symposium — "Problems of Oral Contraceptives"

28 **New Jersey Gastroenterological Society**
Essex House, Newark

29 **Morristown Memorial Hospital**
Morristown
"Pleuropneumonia-like Organisms (PPLO) as Human Pathogens and as Biological Curiosities"

March

1 **Cooper Hospital**
Camden
"The Role of the Internist in the Treatment of the Psychotic Patient"

6 **Camden County Medical Society**
Ladies night — "Family Life Education"

6-9 **New Jersey Academy of General Practice**
Atlantic City

7 **Hudson County Medical Society**
"Current Trends in Medical Malpractice Litigation"

7-8 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Culdoscopy

8 **Cooper Hospital**
Camden
"Recently Appreciated Rheumatic Syndromes"

12 **Bergen County Medical Society**

12 **Essex County Medical Society**
Hotel Suburban, East Orange
"What Can An Office Consultant Do For You?"

12 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Islet Cell Tumors of the Pancreas and Syndromes Associated With Them"

13 **Ocean County Medical Society**

13 **Gloucester County Tuberculosis and Health Association**

13 **The Academy of Medicine of New Jersey**
Mountainside Hospital, Montclair
Symposium on Supraventricular Arrhythmias

13 **Middlesex General Hospital**
New Brunswick
Symposium: "Management of Acute Leukemias"

15 **The Academy of Medicine of New Jersey**
(With Gloucester, Salem and Cumberland County Medical Societies)
Salem County Memorial Hospital
Salem
Symposium: "Oral Contraceptives"

15 **Cooper Hospital**
Camden
"Collagen Disease"

19 **The Academy of Medicine of New Jersey and American Cancer Society (New Jersey Division)**
Newcomb Hospital, Vineland
Symposium: Cancer of the Colon and Rectum

19 **Passaic County Heart Association**
Annual Meyer Notkin Lecture

20 **Middlesex County Medical Society**

20 **Middlesex General Hospital**
New Brunswick
Symposium: "End Results of Treatment of Breast Cancer"

21 **Morris County Medical Society**

22 **Cooper Hospital**
Camden
"When to Hospitalize the Diabetic"

23 **New Jersey State Society of Anesthesiologists**
Cherry Hill Inn, Cherry Hill
9th Annual Postgraduate Seminar

26 **Cape May County Medical Society**

27 **Middlesex General Hospital**
New Brunswick
Symposium: "Management of Early and Late Breast Cancer in Relation to Surgery"

27 **New Jersey Heart Association**
Annual Scientific Seminar

29 **Cooper Hospital**
Camden
"Detection and Long-Term Management of the Ambulatory Diabetic Patient"

April

2 **Hudson County Medical Society**
"Some Psychiatric Problems of Childhood and Adolescence"

3 **The Academy of Medicine of New Jersey**
Princeton Inn, Princeton
Symposium on Adolescence

5 **Cooper Hospital**
Camden
"Modern Trends in the Treatment of Leukemia"

9 **Bergen County Medical Society**

9 **Cumberland County Medical Society**

10 **Ocean County Medical Society**

10 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Biochemical Pharmacology And The Brain"

10 **Gloucester County Tuberculosis and Health Association**

12 **Cooper Hospital**
Camden
"What's New in Dermatology?"

16 **Warren County Medical Society**

17 **Middlesex County Medical Society**

17 **Newark Beth Israel Hospital**
Newark
"Mechanics and Management of Cardiogenic Shock"

18 **Morris County Medical Society**

18 **Gloucester County Medical Society**

19 **Cooper Hospital**
Camden
"Chromosome Aberration in Old Age and Malignancy"

24 **The Academy of Medicine of New Jersey**
Veterans Administration Hospital
East Orange
Dental Symposium — "Periodontal Disease-Etiology and Treatment"

26 **Cooper Hospital**
Camden
"Immunity—Its Role in Health and Disease"

May

1 **Camden County Medical Society**

1 **Passaic County Heart Association**
Symposium or New Concepts in Cardio-Vascular Disease

7 **Hudson County Medical Society**
Election of Officers

8 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Drugs, Poisons, and Membrane Phenomena"

8 **Ocean County Medical Society**

8 **Gloucester County Tuberculosis and Health Association**

9 **Essex County Medical Society**

14 **Bergen County Medical Society**

16 **Morris County Medical Society**

16 **Gloucester County Medical Society**

18-22 **The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Annual Meeting

19 **The Academy of Medicine of New Jersey and The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Symposium on Medicine and Religion

22 **Middlesex County Medical Society**

28 **Cape May County Medical Society**

June

6-7 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Culdoscopy

11 **Cumberland County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"The Thymus — Its Role in Immunity and Disease"

OBITUARIES

Dr. Nicholas F. Alfano

At the untimely age of 57, death came on January 4, 1968 to Nicholas F. Alfano, M.D. He was president of New Jersey Blue Shield and an international authority on physician-sponsored health insurance. Dr. Alfano, born in New York in 1910, was a graduate of George Washington University. He served an internship at Columbus Hospital in Newark and a residency in internal medicine at St. Michael's. He then entered the medical corps of the Army of the United States, joining the Veterans Administration on his demobilization. For five years, he was medical adviser to the rating boards in the New Jersey Regional Office of the VA, and in 1950 was named assistant medical director of the Medical Surgical Plan. In 1957 he became medical director, and in 1962 he was advanced to the presidency of the organization, Two years ago he was elected to the Board of Directors of the National Association of Blue Shield Plans. He was active in the American Public Health Association, and was only recently named to the Royal Society for the Promotion of Health — a well-known and selective British organization. Dr. Alfano was a member of our Essex County Medical Society. An editorial on Dr. Alfano appears on page 43 of this issue.

Dr. Henry D. Bongiorno

At the untimely age of 63, Dr. Henry D. Bongiorno of Paterson died at St. Joseph's Hospital there on December 4, 1967. He received his M.D. in 1929 at the medical school of the University of Maryland. After a brief period of general practice, Dr. Bongiorno became increasingly interested in surgery and, after graduate work in the field, limited himself to that specialty. He became a Fellow of the American College of Surgeons and was on the surgical staff of St. Joseph's Hospital in Paterson. Dr. Bongiorno was active in the affairs of the Passaic County Medical Society.

Dr. Durant K. Charleroy

One of the state's leading anesthesiologists was lost to New Jersey on December 23, 1967 with the death that day of Durant K. Charleroy, M.D. He was born in 1912 and was only 55 at the time of his death. A 1937 graduate of the Hahnemann Medical College of Philadelphia, he completed a residency in anesthesiology, and practiced that specialty in the Trenton area until he was commissioned in the U.S. Navy in 1942. He rose to the rank of Lieutenant Commander, and after being demobilized in 1946 he returned to the practice of anesthesiology. He became a board diplomate in his chosen field, and was invited to Fellowship in the American College of Anesthesiologists. He was associated for many years with the Helene Fuld Hospital in Trenton and, more recently, accepted the invitation to become affiliated with the Perth Amboy General Hospital.

Dr. Steven Fortay

On December 16, 1967, at the age of 65, Dr. Steven Fortay, a Middlesex County otorhinolaryngologist, died at his home after a brief illness. Dr. Fortay was born in Hungary and was a 1928 graduate of the medical school of the Royal Hungarian University. He was affiliated with both the General Hospital in Perth Amboy and the French Hospital in New York City, on the ophthalmology and otolaryngology staffs. Dr. Fortay served during World War II in the medical corps of the Army of the United States, and was in the medical corps reserve thereafter. He was also active in the affairs of the World Medical Association.

Dr. William F. Jamison

One of Monmouth County's busy practitioners, Dr. William F. Jamison, died at the age of 76 on December 9, 1967. In 1955, Dr.

Jamison had an active term as president of the Monmouth County Medical Society. He was a 1915 graduate of the medical school of the University of Louisville and served the people of central New Jersey as a dermatologist for almost half a century. He was in the Army Medical Corps during World War I. Dr. Jamison was on the staffs of the Fitkin Hospital and Monmouth Medical Center.

Dr. Seymour S. Kimmel

Warren County, he used to say, was the one place in New Jersey where one could be a real rural GP. So, after earning his M.D. at Hahnemann in 1932, Dr. Seymour Kimmel settled in the attractive, little town of Oxford New Jersey. He was a general practitioner — and proud of it. He was a country doctor — and loved it. And the people of Warren County loved him. He was active in committee work for our Warren County Medical Society, and was on the staff of the Warren Hospital in Phillipsburg. Dr. Kimmel, born in 1906, died on November 24, 1967 at the age of 61.

Dr. Joseph O. Smigel

Dr. Joseph O. Smigel was one of the American pioneers in geriatrics. He was, from the beginning, active in the affairs of both the American Geriatric Society and the National Society for Gerontology. He served the latter as editor of its journal for many years. Dr. Smigel developed new ideas in setting up and operating homes for the aged, and was a nationally recognized authority on geriatrics, particularly institutional administration in this field. He was the administrator of Pinehaven. Dr. Smigel was interested and skilled in medical editing and writing and was an enthusiastic co-worker in the American Medical Writers Association. He died on November 19, 1967 at the age of 74.

BOOK REVIEWS

Pediatric Plastic Surgery of Trauma. Francis X, Paletta, M.D. St. Louis, 1967, Mosby. Pp. 231 with 419 illustrations. ($27.50)

A price of $27.50 may seem a bit high for a 231-page book. However, this is a magnificent atlas of pediatric surgery for the repair of traumatic wounds and damage due to burns. The book opens with an intensely practical chapter on the equipment and procedures in a hospital emergency room, talks about drains, anesthesia, dressings, and initial repair of lacerations. The subject of tetanus as a complication of wound infection is well treated. Special procedures like tracheostomy or the handling of burns and bites are presented. There is a unique chapter on "wringer" injuries. Everything is illustrated by photographs or by superbly drawn sketches prepared by Elisabeth North. The book concerns children, though much of its material is usable in repairing injuries in adults, too. Every surgeon will feel more comfortable for having this handsome volume available in the emergency room.

RALPH N. SHAPIRO, M.D.

Antilymphocytic Serum (CIBA Foundation Study). Edited by G. E. W. Wolstenholme and Maeve O'Connor. Boston, 1967, Little, Brown and Company. Pp. 165, illustrations 37. (Price not stated.)

Recent publicity regarding human organ transplantation makes this book concerning antilymphocytic serum most appropiate. Antilymphocytic serum is a globulin produced by injection of human or heterologous animal lymph node, spleen, or thymic homogenate into another animal. It causes a decrease in human or animal lymphocyte production and alters the ability of lymphoid tissue to produce antibodies, especially to homografts. The book is a collection of papers concerning the methods of production of antilymphocytic serum, the mechanisms of its action, its experimental uses and its present and future practical use.

The participants in the study group are internationally recognized authorities on lymphocyte transformation and lymphocyte antibody production. In addition to presenting the papers in their entirety, the book reproduces the extensive discussion following each paper, the bibliographic references, and the final discussion at the completion of the seminar.

This publication will prove vitally interesting and highly useful to those contemplating organ transplantation (including bone marrow) and, of course, to all pathologists, hematologists, oncologists and allergists.

MELVIN H. FREUNDLICH, M.D.

Roentgenologic Diagnosis. J. George Teplick, M.D., Marvin E. Haskin, M.D., and Arnd P. Schimert, M.D. Philadelphia, 1967, Saunder. Pp. 1198 (two volumes). Illustrated. ($38)

This atlas of roentgenograms is associated with Beeson and McDermott's *Textbook of Medicine*. The organization of the book is unique in that the arrangement of diseases follows the *Textbook of Medicine*, so that diagnostic criteria for each disorder are discussed under the disease entity, rather than being grouped under radiographic appearance or organ system.

The 2000 illustrations are well reproduced and well labeled. The text is concise, limited mainly to the interpretation of the x-ray studies. Clinical, physiologic, and pathologic aspects of the diseases are readily available in the companion basic medical textbook. The differential diagnoses of the x-ray findings are not given; but adequate references to the current literature are available for anyone wishing to study a subject in greater depth.

The diagnostic x-ray findings in specific disease entities are fully outlined. This information is essential to the practitioner or internist in planning an intelligent diagnostic work-up. An understanding of which studies to obtain and what to expect from these studies is the principle value of this book.

Roentgenologic Diagnosis is neither a textbook of radiology nor a textbook of medicine. It is an atlas of the x-ray appearance of diseases which supplements a standard medical textbook. Anyone using the Beeson and McDermott *Textbook of Medicine* should find much use for this book. It should greatly appeal to internists, medical residents, and students — rather than to radiologists. JAMES J. STOVIN, M.D.

Myotatic, Kinesthetic and Vestibular Mechanisms. (Ciba Foundation Symposium). Edited by A. V. S. DeReuck and Julie Knight. Boston, 1967, Little, Brown and Company. Pp. 331. Illustrated. ($13.50)

The Ciba Foundation, with this symposium, has continued its series on sensory function focusing on different aspects of the sensory control of posture and movement. The clinical and laboratory data of twenty-six investigators on myotatic, kinesthetic and vestibular mechanisms are presented from diverse viewpoints followed by stimulating and timely discussions. The material crosses the domain of many specialists; and indeed, many different fields are well represented in the symposium — from the neurophysiologist and otolaryngologist to the zoologist. The book is divided into four sections. The subject matter of the first is myotatic and kinesthetic mechanisms. The other three sections include details of the vestibular mechanisms — the ultra-structure, nerve pathways and clinical aspects. Each presentation is followed by a detailed discussion which, in some instances, is as interesting and informative as the paper discussed.

A wealth of valuable material is presented in this symposium which should be of interest to a variety of medical specialists, particularly the otologist and the neurologist. Here is a vital reference work as well as a stimulus for further investigative studies in this interesting field. The need for ultramicroscopic technics as an adjunction to classical histologic methods and light microscopy is emphasized.

RAYMOND B. STRAUSS, M.D.

The Technic of Psychotherapy Ed. 2. Lewis R. Wolberg, M.D. New York, 1967, Grune and Stratton. Two volumes. Pp. 1411. With numerous charts, appendices and case histories. ($29.75).

Since 1954, this has been a standard work in the field. The present edition is expanded and updated. Wolberg is no dogmatist. He does not spurn medication, for example. On the contrary he recognizes its value, and suggests drugs, dosages, and conditions of use. The book has amazing breadth, covering almost anything one can think of in the entire spectrum of psychotherapy.

The author lists varities of psychotherapy; he quotes and analyzes (in the semantic not the psychiatric sense) dozens of definitions of therapy. He offers frank discussion of the value of psychotherapy, points out the lack of hard "objective" evidence of its value, says something about research methods designed to appraise its effectiveness. He reviews supportive, reconstructive and reeducational technics. There is a chapter on the training and intellectual equipment needed to do psychotherapy. There is another on the mechanics of the therapeutic interview. Common questions raised by patients about psychotherapy and ways of answering these questions are presented. The author gives pointers on recognizing and handling resistance, on terminating treatment. These suggestions are not merely stated abstractly. Wolberg gives actual samples of case reports and interviews to illustrate his advice to therapists.

The text includes a candid report on failures in therapy. There is discussion of short term, emergency and group therapies. The place of psychotherapy in community mental health centers is discussed. The therapist's recording technics are reviewed.

Nor does Wolberg stop there. He salts his text with many actual case reports and verbatim transcripts. He offers a reading list to which the general practitioner may turn for further details. A useful appendix includes sample history sheets, progress note forms, patients' information circulars, and even an outline of relaxing exercises. This ambitious work can be enjoyed by, and will be helpful to, the sophisticated general practitioner, internist, or pediatrician as well as to the psychiatrist. The text is well anchored in the realities of day by day practice. ABRAHAM LEFF, M.D.

Micro-Vascular Surgery. Edited by R. M. Donaghy, M.D. and M. G. Yasargil, M.D. St. Louis, 1967, Mosby. Pp. 171. 217 illustrations. ($17.50)

How do you anastomose an artery less than a millimeter wide — and keep it patent? I don't know either, but here is a report of a conference on micro-vascular surgery held at the Fletcher Hospital in Burlington, Vermont in October 1966. Much of the work is done under the operating microscope (with 6 to 40 power magnification). Papers presented at this conference (and detailed and illustrated in this beautiful little book) cover the use of liquid plastics in repair, bipolar coagulation, electro-coaptation, microvascular stapling, analysis of the fluid mechanics in blood flow, the effect of laser on blood vessel walls, how to apply vascular compression of the fifth nerve in trigeminal neuralgia, and the surgery of intracrania blood vessel occlusion. This is a gem of a book covering a new, effective, and exquisite branch of surgery.

VICTOR HUBERMAN, M.D.

Charities and Corrections in New Jersey. By James Leiby, Ph.D. New Brunswick, 1967, Rutgers University Press. Pp. 498. (Price not stated)

New Jersey is one of the few states which consolidates into a single executive department its mental hospitals, penal institutions, and welfare operations. Organized in 1905 as the Department of Charities and Corrections, it became in 1918 the Department of Institutions and Agencies. While neither title embraced words like medicine, hospitals, or health, the truth was that from the beginning, state (and, to some extent, county) hospitals were involved, and organized medicine played an important role. It was a commission of physicians who, in 1865, first proposed central sanitary supervisions of State and County institutions. The medical profession, in 1922, hammered home the point that mental institutions must be general hospitals, too. Physicians stimulated the country's first tax-supported child guidance clinic (then called the Essex County Juvenile Clinic, directed by James S. Plant) and it was The Medical Society of New Jersey that prompted the State's first network of mental health clinics. The program for educating the public about epilepsy, and taking off its "hereditary taint" curse, is credited to The Medical Society of New Jersey. And it was a group of New Jersey physicians who in 1958 developed the increasing use of open wards in mental hospitals. Although no Commissioner of the Department had ever been a physician, the influence of the medical profession played an effective and honorable role in its growth.

This book traces state welfare, medical, and penal institutions and agencies from their colonial beginnings in the 1740s to the death of Commissioner Tramburg a few years ago. The author offers shrewd, often critical comments on the key personalities involved. The narrative is not a dull history but a lively kaleidoscope of people and events. The tribulations and triumphs are all detailed, and any one interested in welfare work in our State will be enriched by reading these pages.

HENRY A. DAVIDSON, M.D.

The Living Poor. Camille Jeffers. Ann Arbor, Michigan, 1967, Ann Arbor Publishers. Pp. 123. Paperback. ($2.00)

Perhaps an "E" for effort would be the right score here. Mrs. Jeffers is a participant-observer who has lived in public housing developments and learned in this way something of the actual life of the inarticulate poor. Even the author's best friends could hardly call this book a scientific study or a stimulating report. It is distressing to note so little of what might be called "professional intervention" in the daily lives of her subjects. On the other hand, one cannot help but be impressed with the inner strengths of the families selected for this study. Whether this is a valid sampling, or whether Mrs. Jeffers consciously or unconsciously selected the ones with greater strengths is hard to say in the absence of any description of the sampling technic. At any rate, one thing seems clear: helping families requires *concern,* not fanfare or impressive words.

Once swept into a corner or under the rug, the poor have become popular subjects for authors these days. Of course, those of us in the helping professions are a long way from knowing *how* to do it in any completely effective sense. Is Mrs. Jeffers implying that the only way to help them is to live with them? Public housing is only part of the complex picture of the poor, and Mrs. Jeffers does not fit the part into the whole. Certainly the author has acquired first-hand knowledge of life in a "project." But she does not seem to have related herself to the operations of the public and private agencies available to correct the admitted deficiencies in public housing. In spite of some of these flaws in ths text, it is, all in all, a good prologue to the problem.

NORMAN M. GERBER

Books Acknowledged or Received

Alcoholism. Edited by Ruth Fox, M.D. Springer Publishing Company, 44 East 23 Street, New York City. Pp. 340. Price not stated.

An anthology of 30 papers on various phases of alcoholism.

Essays in Self-Destruction. Edited by Edwin S. Schneidman, Ph.D. Science House. 59 South Ave., New York City. 1967. Pp. 554. ($12.50)

Two dozen essays on suicide, ranging from Shakespeare to Herman Melville, with descriptions of suicide-prevention centers, the social structure of Japan, the psychology of accidental death, and the approach of the forensic patholgist.

Comparative Psychopathology: Animal and Human. Edited by Joseph Zubin, Ph.D. and H. F. Hunt, Ph.D. Grune & Stratton, 381 Park Avenue South, New York City. 1967. Pp. 349. ($15.75)

The transactions of the 1965 meeting of the American Psychopathological Association, bound into book form. Fourteen essays on emotional and social behavior in animals and the analogizing of these activities to problems in human beings.

Light on Dark Corners. B. Jefferis, Ph.D. and J. L. Nichols, M. A. Grove Press. 80 University Place, New York City. (a 1967 reprint of an 1894 book). Pp. 247. ($5)

When this book was written (1894) Anthony Comstock attacked it as immoral. It is seen now as a pathetic attempt to give sound, pietistic, obvious advice to men and women on the brink of marriage. Now available as an historical curiosity.

The Psychiatric Emergency. Raymond Glasscote, M. A. and others. Published by the American Psychiatric Association, 1700 NW 18 Street, Washington, DC 20009. Pp. 111. Paperback. 1966. ($2.50)

A report on what various hospital's mental health centers do about psychiatric emergencies.

Drug Responses in Man. Edited by G. Wolstenholme and R. Porter. Boston 1967. Little Brown. Pp. 257. ($13.00)

Transactions of an international conference on the effects of various drugs on man. It covers pharmacology, metabolism, allergy, and toxicity. A dozen authorities contributed to the symposium. The informal discussion of each paper is also included.

Treatment of Alcoholism. Raymond Glasscote, M.A. and others. American Psychiatric Association and National Association for Mental Health. Published 1967 by the American Psychiatric Association at Washington, DC 20009. Pp. 155. Paperback. ($3.00)

A review of what eleven selected programs do about alcoholism.



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There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

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new evidence for TAO® (triacetyl-oleandomycin)

a macrolide antibiotic for the frequently seen respiratory infection in the office and for a problem pathogen* in the hospital.

*Staphylococcus aureus

study I[1]

Results of a 1967 in vitro—in vivo correlation study involving 116 patients with Gram-positive coccal infections in five institutions. All patients were given TAO prior to determining the susceptibility of the offending organism.

97.0%
of the organisms were susceptible to oleandomycin*

98.0%
of the patients responded favorably to TAO® (triacetyloleandomycin)

*In some cases more than one pathogenic organism was isolated from the patient.

study II[2]

Effect of oral therapy with TAO, erythromycin, and cloxacillin on the survival time of Rhesus monkeys after intravenous inoculations of lethal doses of staphylococci, phage type 80/81.
(8 monkeys in each group)

conclusion:

*Under the conditions of this study and the doses employed, it was found that

TAO® (triacetyl-oleandomycin)
was far superior to erythromycin, as was cloxacillin, a bactericidal agent, and of particular interest, "...bacteriostatic triacetyloleandomycin was as effective or perhaps superior to cloxacillin in preventing lethal (staphylococcal, phage type 80/81) infection."

*It should be pointed out that results obtained in an experimental study of this nature may not necessarily be directly extrapolated to the clinical situation as it pertains to man.

TAO Rx Information

INDICATIONS: Include streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents.

CONTRAINDICATIONS AND PRECAUTIONS: Not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. When treating gonorrhea in which lesions of primary or secondary syphilis are suspected, proper diagnostic procedures, including darkfield examinations, should be followed. In other cases in which concomitant syphilis is suspected, monthly serological tests should be made for at least four months. Contraindicated in pre-existing liver disease or dysfunction, and in individuals hypersensitive to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. When used in streptococcal infections, therapy should be continued for ten days to prevent the development of rheumatic fever or glomerulonephritis. The use of antibiotics may occasionally permit overgrowth of nonsusceptible organisms. A resistant infection or superinfection requires re-evaluation of the patient's therapy. In the event such occurs with this drug the medication should be discontinued, and specific antibacterial and supportive therapy instituted.

References: 1. Isenberg, H. D.: Clinical Evaluation of Laboratory Guidance to Antibiotic Therapy; Health Laboratory Science (July) 1967. 2. Saslaw, S., Carlisle, H. N.: Studies on Therapy of Staphylococcal Infections in Monkeys. 1. Comparison of Cloxacillin, Triacetyloleandomycin and Erythromycin. Proc. Soc. Exp. Biol. & Med.: Vol. 125, No. 4 (Aug.-Sept.) 1967.

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HALT DIARRHEA!
SHERIFF

LOMOTIL®

TABLETS / LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . . 2.5 mg.
(Warning: may be habit forming)
atropine sulfate . . . . . 0.025 mg.

Halts Diarrhea Promptly

in children with . . . Gastroenteritis ▪ Spastic bowel
Influenza-like infections ▪ Antibiotic-induced diarrhea

Lomotil helps get children with diarrhea off toast and tea and back to normal diets and normal activity with gratifying dispatch. ▪ Lomotil lowers intestinal motility and permits absorption of excess fluid. This usually controls diarrhea promptly. ▪ Moreover, lowered intestinal motility achieved with Lomotil often relieves the abdominal cramps and discomfort so distressing to children.

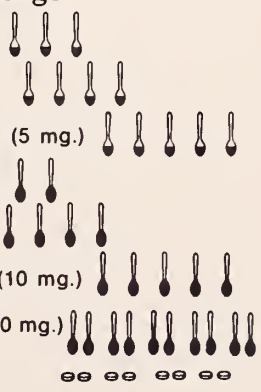
recautions: Lomotil is a Federally exempt arcotic preparation of very low addictive otential. Recommended dosages should ot be exceeded, and medication should be ept out of reach of children. Should acci- ental overdosage occur signs may include evere respiratory depression, flushing, thargy or coma, hypotonic reflexes, nys- gmus, pinpoint pupils, tachycardia; ntinuous observation is recommended. omotil should be used with caution in pa- ents with impaired liver function or those king addicting drugs or barbiturates.

de Effects: Side effects are relatively un- mmon but among those reported are strointestinal irritation, sedation, dizzi- ess, cutaneous manifestations, rest- ssness, insomnia, numbness of the tremities, headache, blurring of vision, elling of the gums, euphoria, depression d general malaise.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . .½ tsp.* t.i.d. (3 mg.)
6-12 mo. .½ tsp. q.i.d. (4 mg.)
1-2 yr. . . .½ tsp. 5 times daily (5 mg.)
2-5 yr. . . .1 tsp. t.i.d. (6 mg.)
5-8 yr. . . .1 tsp. q.i.d. (8 mg.)
8-12 yr. . .1 tsp. 5 times daily (10 mg.)
Adults: . .2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.



*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

SEARLE *Research in the Service of Medicine*

When the agitated businessman goes to work...

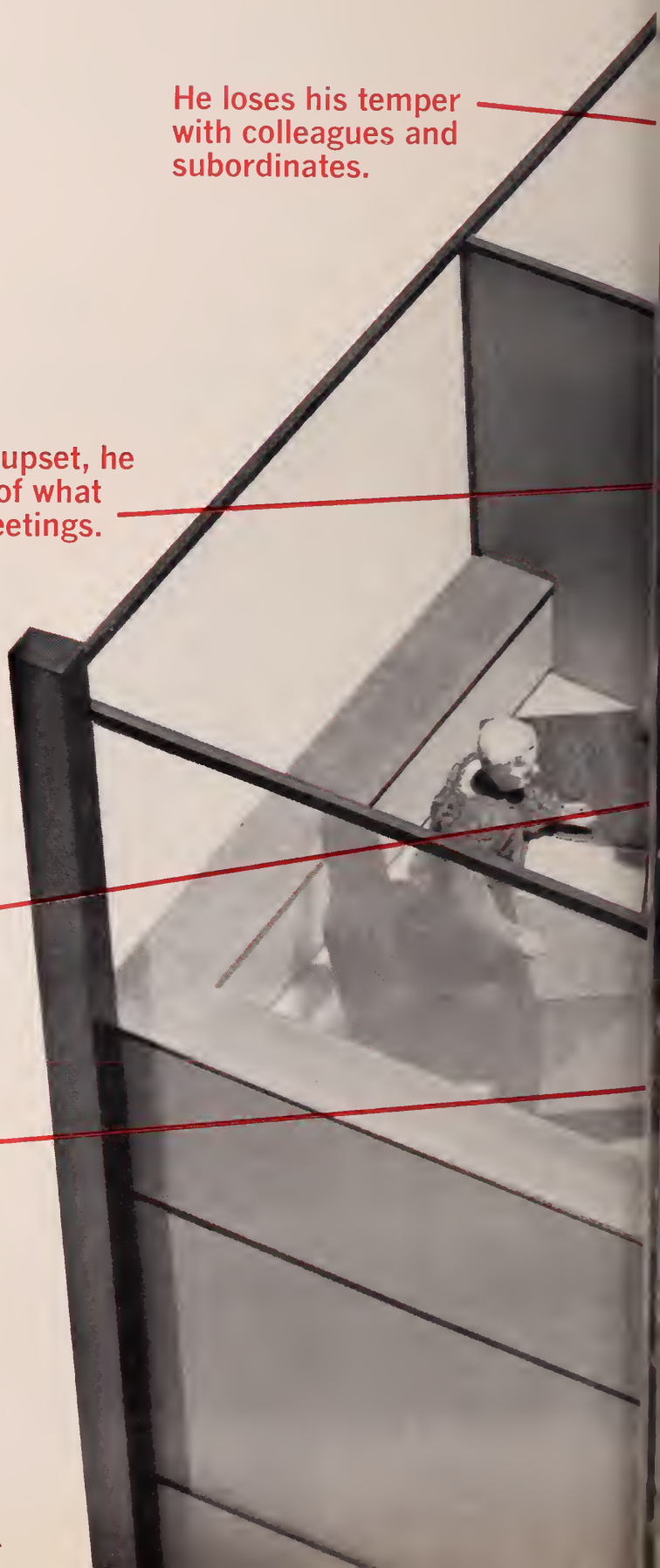
He goes home at night and takes it out on his family.

He loses his temper with colleagues and subordinates.

Emotionally upset, he misses half of what is said at meetings.

He is always fearful about his standing with the boss.

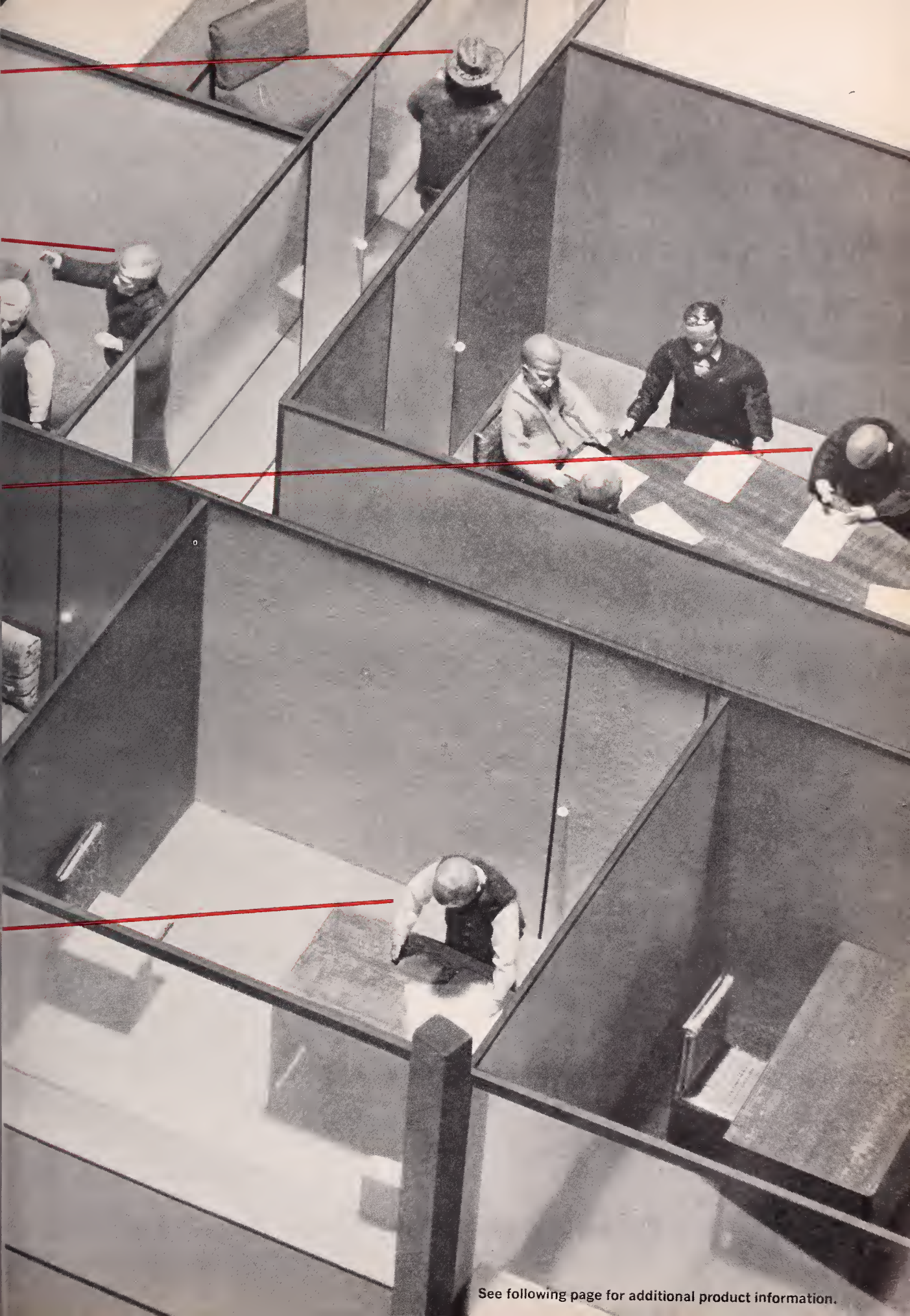
He just can't seem to settle down to his work.



for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ



See following page for additional product information.

When the agitated businessman goes to work...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

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Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

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Dispensed in bottles of 100 and 1000 tablets.

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MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. A brief precautionary statement follows.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use cautiously, especially in the first trimester. *Note:* The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.



a stuffy nose is no laughing matter

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Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

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brand of sustained release capsules

each one can give him all-day or all-night relief of nasal congestion

SK&F Smith Kline & French Laboratories


in moderate hypertension and
poorly controlled mild hypertension
(when diuretics or sedatives are inadequate, for example)

When your patients expect a lot...

like relief from hypertensive symptoms
(headache, fatigue, nervousness, palpitation or insomnia, for example)

like an up-to-date, once-a-day dosage schedule
(a schedule not unlike timed-release medication, for example)

like a daily dose of medication for peanuts
(at 10¢ a tablet, for example)

like generally well-tolerated therapy
(as described in the package insert, for example)

...give them a little
(one tablet daily)

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chlorthalidone 50 mg., reserpine 0.25 mg.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Regroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-B
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this issue: the cold in pregnancy...

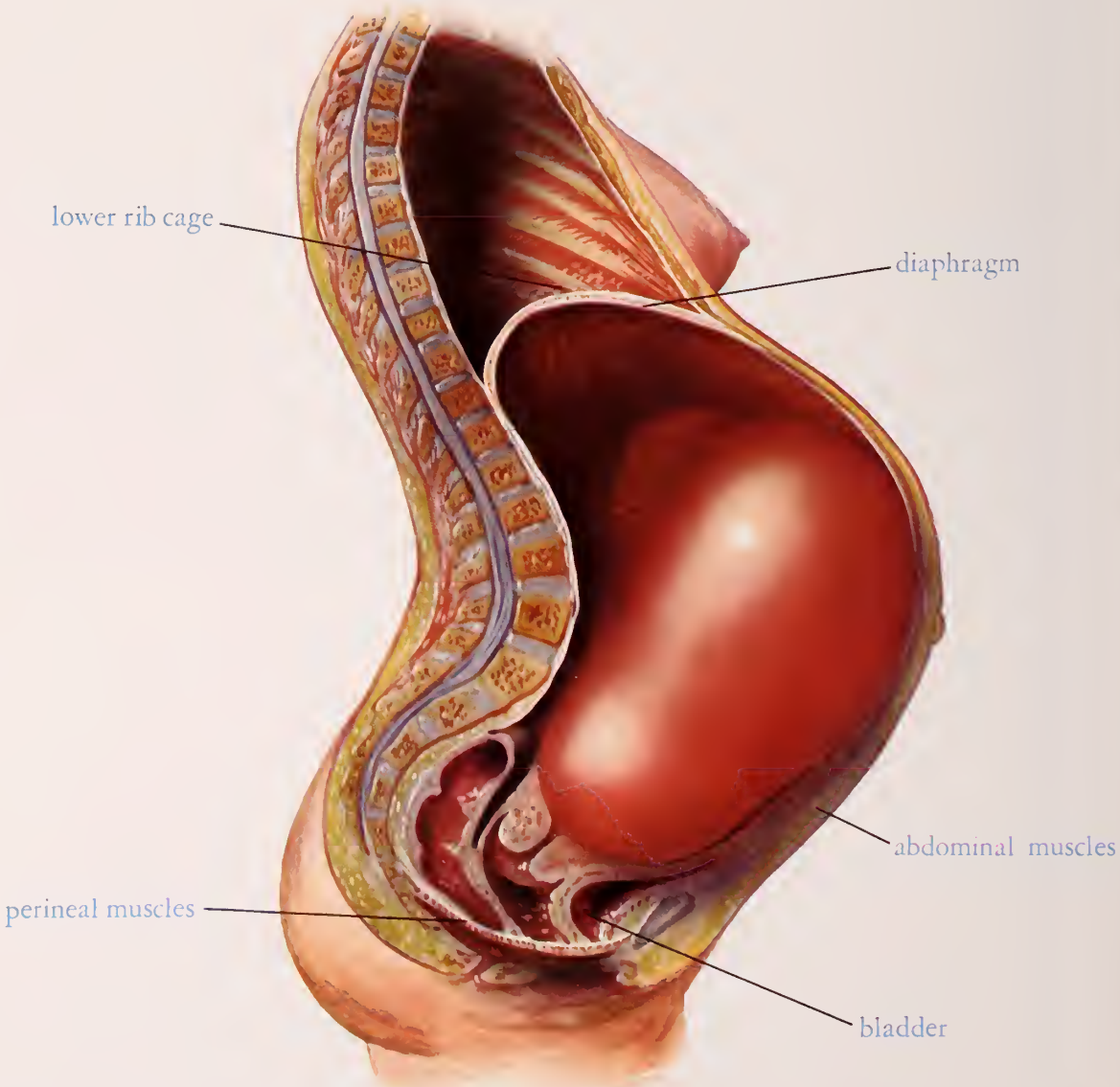
the cold in pregnancy

Frederick W. Goodrich, Jr., M.D.
Senior Obstetrician and Gynecologist, Lawrence and Memorial Hospital, New London, Connecticut

Since pregnancy and the common cold are both ubiquitous, it is not surprising that they often occur at the same time in the same patient. Incidence figures are hard to come by, but the chances are very good that any given pregnant woman will have a cold at some time during the nine months of her gestation. When she does, she will tell you that it is the worst cold she ever had. It seems to last longer and the symptoms are more distressing than they are in the non-pregnant.

For purposes of this discussion, the common cold i considered to be the well-known symptom complex which includes sore throat, stuffy nose, and a cough Febrile states or extension of the disease proces into the lower respiratory tree are not part of th common cold and will not be included in this dis cussion.

The clinical picture of a cold in pregnancy can b confused by a long-known physiological phenome



non. Kiesselbach's area in the nose (on the anterior part of the nasal septum above the intermaxillary bone) becomes engorged, apparently due to hyperemia induced by the increased estrogen level which accompanies pregnancy. The amount of congestion can vary in degree from woman to woman. Some have very little congestion, others will have occasional nosebleeds from this area, still others will have symptomatic congestion to the degree that they will complain of having a "chronic" or constant cold.

Less well recognized is the occurrence of this type of hyperemia in any part of the nasopharyngeal mucosa, again in varying degree. Such swelling often produces a postnasal drip which, the patient will state, is present only when she is pregnant. Patients who do not have symptomatic congestion ordinarily, will find that when they do get a cold, the symptoms last much longer than those of a cold usually do. Occasionally, this hyperemia is responsible for closure of the medial end of the Eustachian tube; such patients will complain of "plugging" of the ears. Inspection of the ear drum will show a depression which confirms the presence of Eustachian closure rather than wax in the canal which is the patient's diagnosis. Symptoms related to this physiological congestion are more apt to occur in heavier smokers or those who have a history of allergic rhinitis, just as are the symptoms of the common cold. And when the cold does occur in pregnancy, the symptoms are worse because of the underlying congestion.

The pregnant woman with a cold is miserable for other reasons, dependent somewhat on her parity and the length of her gestation. As parity increases, so also does the relaxation of the abdominal and perineal musculature. The uterus, lying against a slack abdominal wall, and bearing down on relaxed perineal muscles, acts like a piston when the patient coughs, sneezes, or even blows her nose, pushing down on the bladder. Stress incontinence during colds is almost the rule.

As the length of gestation increases, so does the size of the uterus. As it grows, it pushes the abdominal contents above it and elevates the diaphragm. This results eventually in a lateral displacement of the lower rib cage, often to a point at which the patient will complain of soreness in this area. If such a

(Concluded on following page)

From a continuing study on nasal congestion...



timed to work while your patient does

A study begun in 1966 by the Department of Otolaryngology, Greater Baltimore Medical Center, has accumulated evidence that documents the effectiveness of Triaminic's timed-release action in the treatment of nasal congestion.

With its balanced formulation of an oral nasal decongestant and two antihistamines, Triaminic effected partial or complete relief in more than 82% of the 85 subjects treated. Clearing nasal obstruction. Reducing turbinate swelling. Making breathing easier.

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Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50mg.
Pyrilamine maleate	25mg.
Pheniramine maleate	25mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)

patient has a cold, the coughing and sneezing will exaggerate this soreness. The diaphragmatic restriction caused by the enlarging uterus also makes breathing more difficult, particularly when the patient lies down. A cold compounds this difficulty.

Treating a cold in pregnancy requires two additional considerations. The patient should be told that the symptoms may last longer lest she become discouraged, and she should be reassured that the treatment will not damage the fetus. Although there are still some women who seem blissfully ignorant regarding matters of health (and these need to be cautioned not to take medication recommended by friends), most of our maternity patients are aware of the thalidomide tragedy. These women need constant reassurance that the symptoms of a cold can be treated, and that the medication is safe. Fortunately, many of the drugs which are of benefit have been in use long enough and widely enough so that such a statement can be offered. Occasionally one encounters a patient who is so anxious to avoid medication that she is extremely reluctant to take anything at all. Since cold is self-limited, it seems reasonable enough to give such a patient the choice and not to force drugs on her if she is obviously afraid of taking them.

The most distressing symptom of the common cold is the nasal congestion. This can be mitigated by the use of a decongestant which will help reduce the postnasal drip and the coughing caused by it. The kind of a cough which is described as a "tickling" in the throat and which is apt to occur when the patient goes to bed is usually due to nasopharyngeal congestion rather than inflammation in the lower respiratory tract.

There are many cough mixtures available. Most contain an antihistamine, a decongestant, and a cough "suppressant." Should cough suppression be desirable, it is important to remember not to use both a decongestant tablet and such a cough mixture as the patient would be getting a double dose of the decongestant. With some patients, the placebo effect of a cough syrup may be important and a liquid preparation might be substituted for an oral tablet.

For a sore throat, candy drops or lozenges at frequent intervals are soothing. It is not only unnecessary but unwise to use antibiotic lozenges or drops. The use of antibiotics in an uncomplicated cold is contraindicated and should be scrupulously avoided.

In summary, a cold in pregnancy is more severe and longer lasting. The treatment of the symptoms with local and systemic decongestants will make the patient more comfortable.

Apparently the cold is so common in pregnancy that it has received very little attention in the literature. References are almost non-existent and the few which are available add little to the common knowledge, are out-dated, or are not helpful. Thus the usual bibliography is not appended.



Relieve his sniffles, her concern, and about half your phone calls. Tell her to get "The Orange Medicine"



Triaminic® syrup

Each teaspoonful (5 ml.) contains:

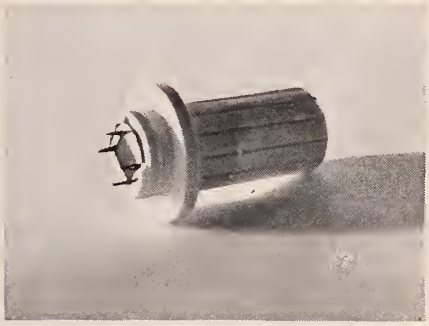
Phenylpropanolamine hydrochloride	12.5 mg
Pheniramine maleate	6.25 mg
Pyrilamine maleate	6.25 mg

For nasal congestion you can bring quick, lasting comfort to your little patients with Triaminic Syrup. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

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Make tuberculin testing routine with every physical examination.



TUBERCULIN, TINE TEST (Rosenthal)

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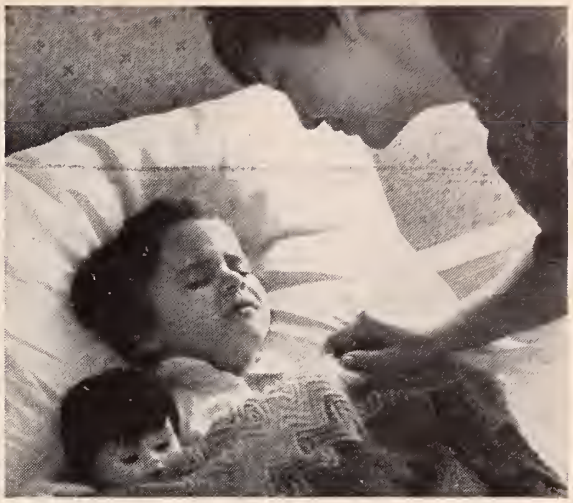
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Parepectolin for quick relief of acute diarrhea
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...adsorbs irritants with kaolin, and protects intestinal mucosa.

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

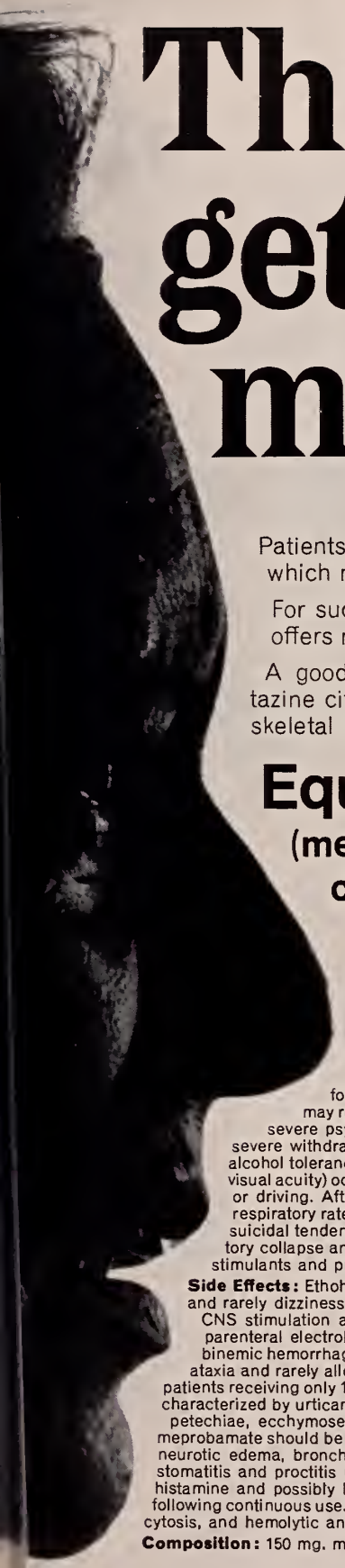
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Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.
Usual Children's Dose: One or two teaspoonfuls three times daily.

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This pain is getting on my nerves.

Patients in pain often experience concomitant anxiety and tension, which may add to the burden of pain.

For such patients, you may want to prescribe a preparation that offers more than simple analgesia.

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Equagesic® TABLETS

(meprobamate and ethoheptazine citrate with aspirin)

Wyeth

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.



Nothing else I've tried seems to work, so I decided to give you a crack at it.

Some U.R.I. patients are more miserable than others.

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And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.



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Except with Butazolidin® alka.

If it doesn't work in a week,
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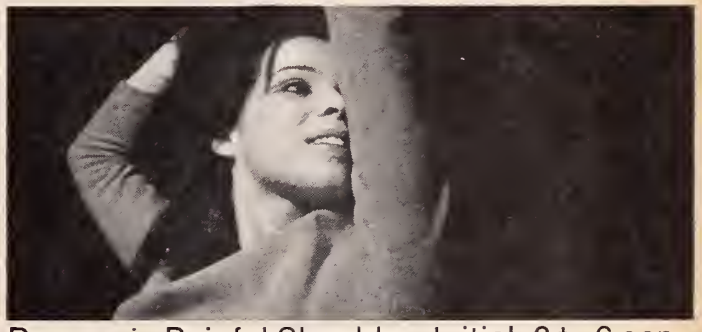
But don't forget this about Butazolidin alka

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Painful Shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: one week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

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phenylbutazone, 100 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate, 150 mg.; homatropine methylbromide, 1.25 mg.

For complete details, please see full prescribing information.

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Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persits for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

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METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



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Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

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METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

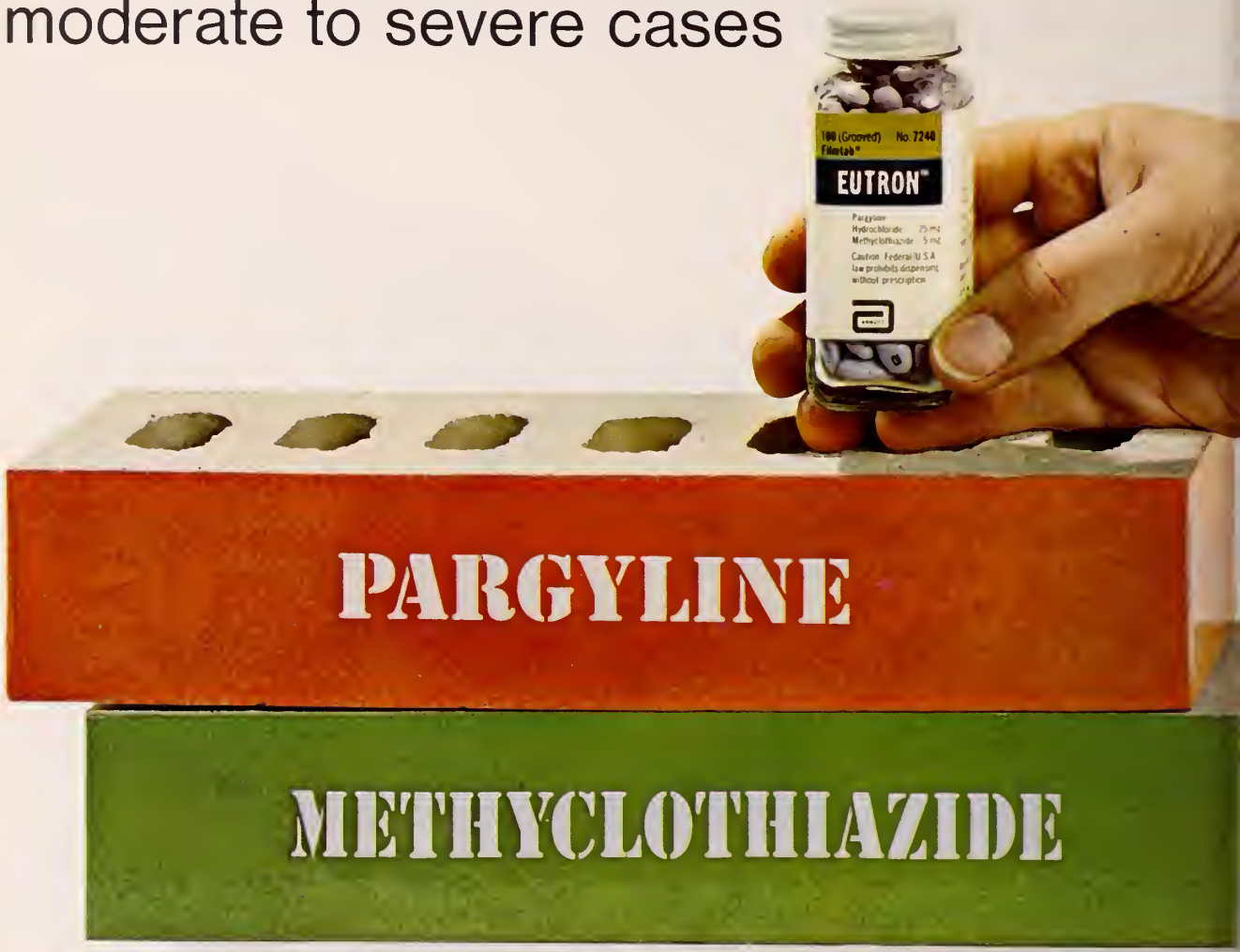
MILD TO MODERATE TO SEVERE



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Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

80109-

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amendable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-TRADEMARK

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅓ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

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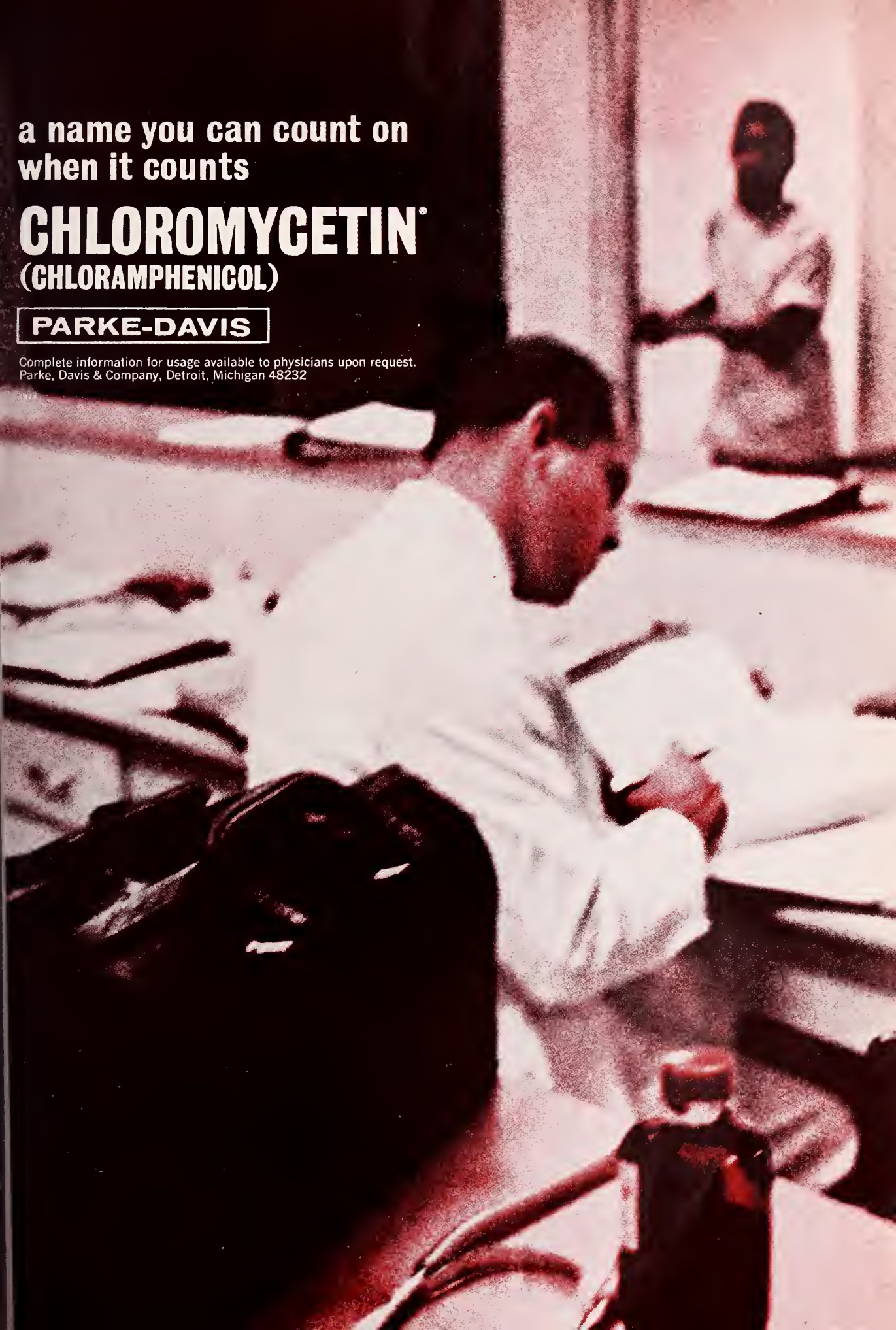
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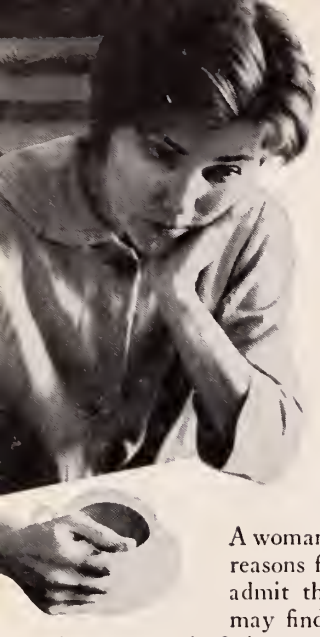
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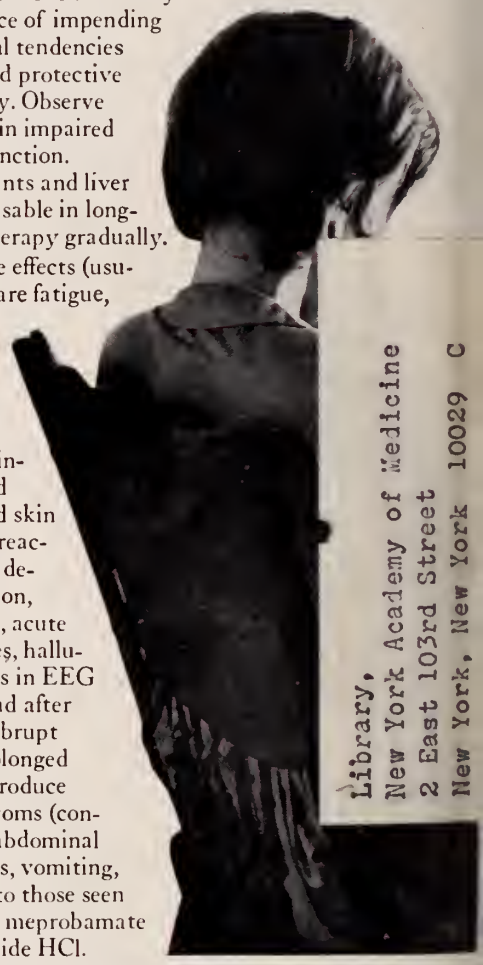
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MARCH 1968
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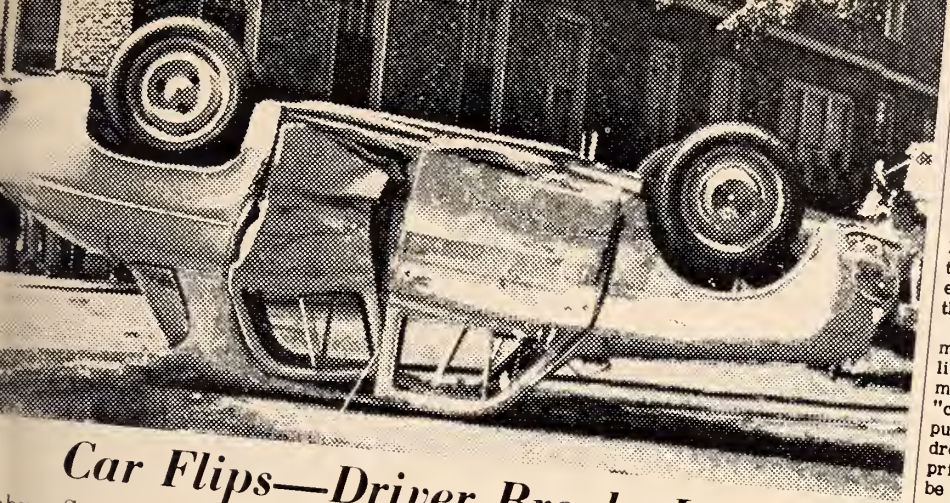
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Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** 1 or 2 capsules at 2 to 4 hour intervals, or as directed by physician. For further details see product literature.

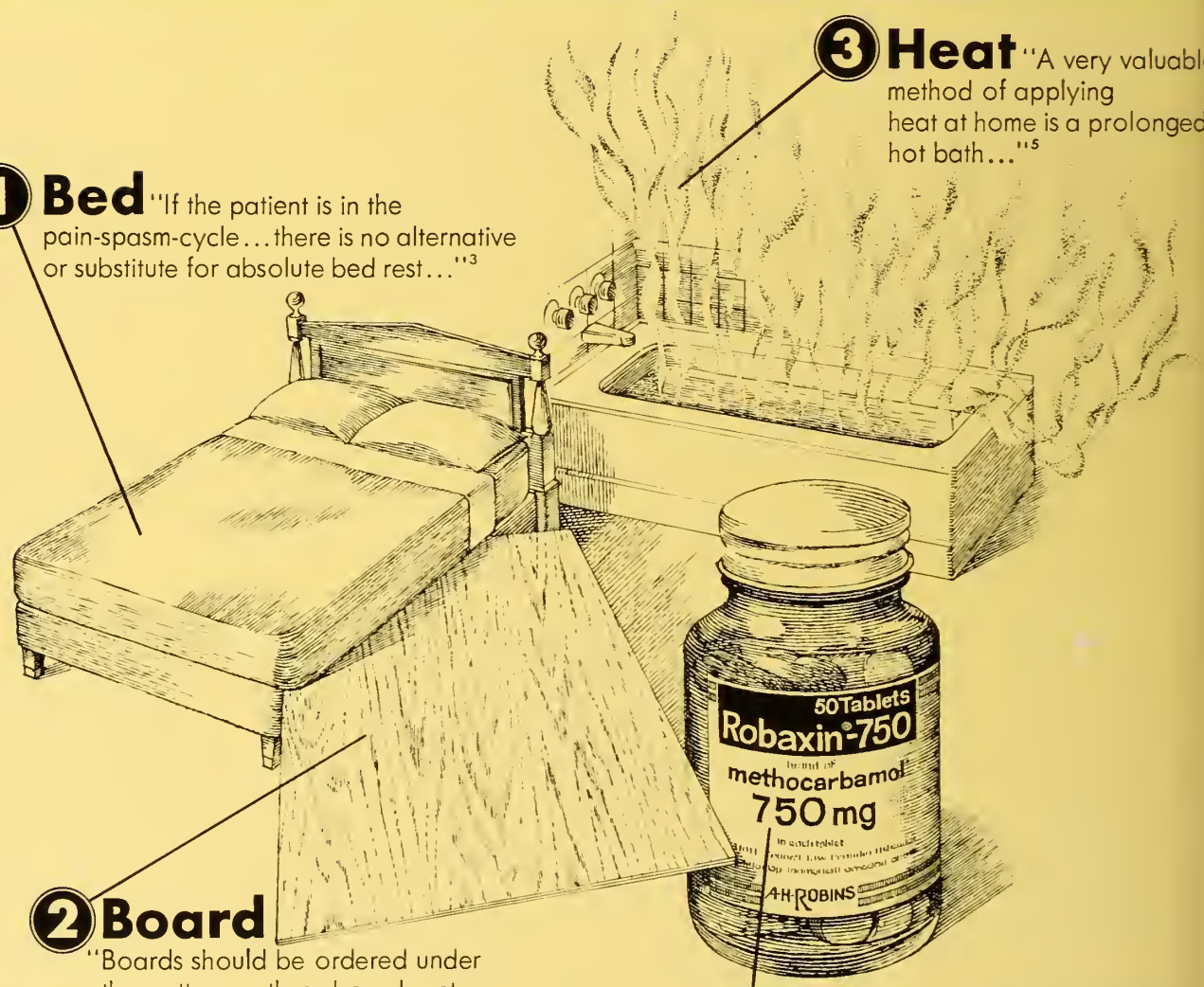
A. H. ROBINS COMPANY
RICHMOND, VA. 23220 A·H·ROBINS



LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

Indicated for relief of skeletal muscle spasm. **Contraindicated** in hypersensitive patients. **Side Effects** (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. **Also available:** Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

References: (1). Gadfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gattschalk, L.A.: GP 33:91, 1966. (3). Rawe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cazen, L.: Sauth Dakata J. Med. 18:26, 1965. (5). Sata-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteapath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 23220



tones down the "explosive gut"

helps restore normal motility and tone

CANTIL®
(mepenzolate bromide)

Diarrhea and other symptoms of common G.I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

LAKESIDE

CONTRAINDICATIONS: Sensitivity to Cantil® (mepenzolate bromide), glaucoma, G.I. or G.U. obstruction, toxic megacolon. **WARNINGS:** Possibility of adverse reactions in advanced severe ulcerative colitis and atypical agitated reactions to phenobarbital in the elderly (Cantil with Phenobarbital). **PRECAUTIONS:** Cantil is of adjunctive use only; treatment of the underlying condition is indicated, be it organic or functional. Observe caution in conditions known to be incompatible with atropine-like drugs, e.g., open-angle glaucoma or prostatic hypertrophy. **ADVERSE EFFECTS:** Dry mouth; blurred vision; constipation; nausea; vomiting; bloating; dizziness; urinary retention. All are anticholinergic effects and usually tolerable. Habituation and idiosyncratic reactions to phenobarbital (Cantil with Phenobarbital) are possible, as is generalized rash. **DOSAGE:** One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required. **HOW SUPPLIED:** CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

An anorectic will help her lose weight–
but can she keep it off?
You need more than a pill
(even ours) to do that!



That's why Abbott offers you a pill plus a program.

ABBOTT

The Product

For smooth appetite control plus mood elevation

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form



For patients who can't take plain amphetamine

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital



DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital



The Program

Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably—and permanently. There is, also, a comprehensive list of foods showing their caloric content.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

801444



Please see Brief Summary on next page.

Ask Your Abbott Man For Free Supplies

Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

ABBOTT

801444

Q. How much does the **anticostive*** **hematinic** cost?

A. No more than costive hematinics cost!

The anticostive hematinic is
PERITINIC®
Hematinic with Vitamins and Fecal Softener

A tablet-a-day provides:

● Elemental Iron (as Ferrous Fumarate)	100 mg
● Dioctyl Sodium Sulfosuccinate (to counteract constipating effect of iron)	100 mg
Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*
anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

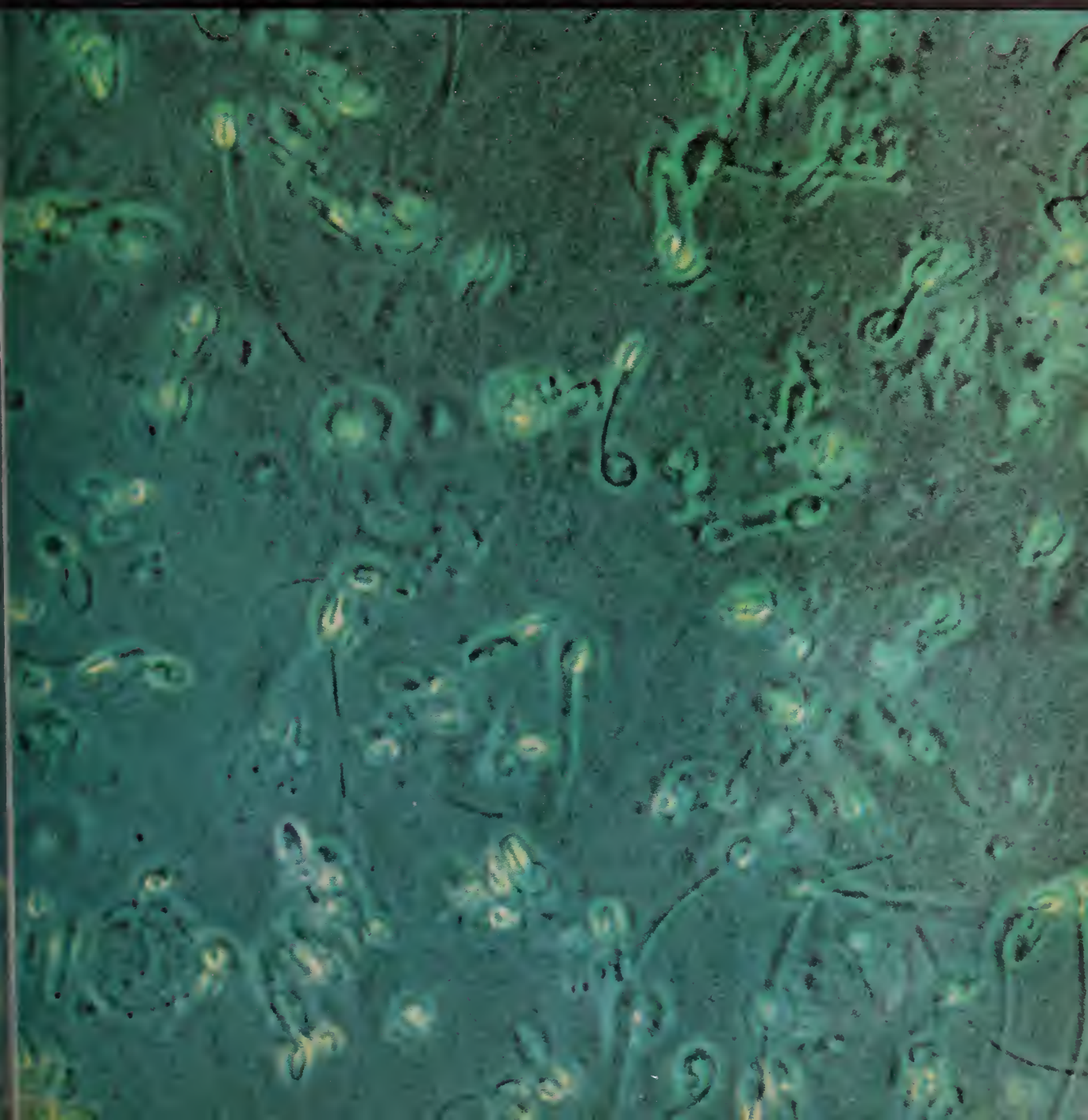
Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

490-7—6064

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. & mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretion, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, change in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching.

The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has been neither established nor disproved): thrombophlebitis, pulmonary embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF

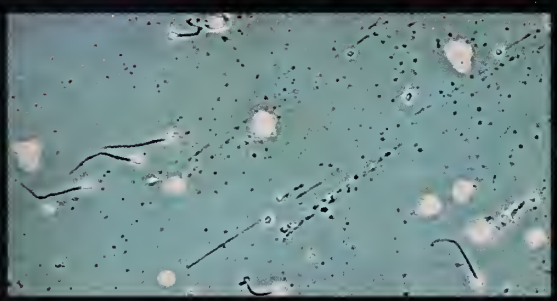
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

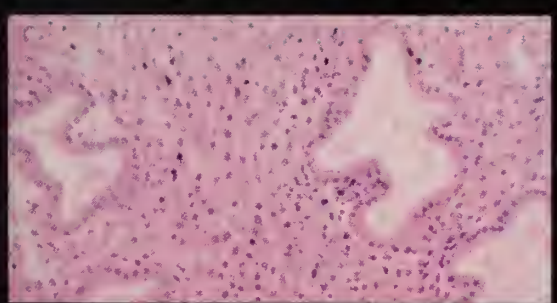
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

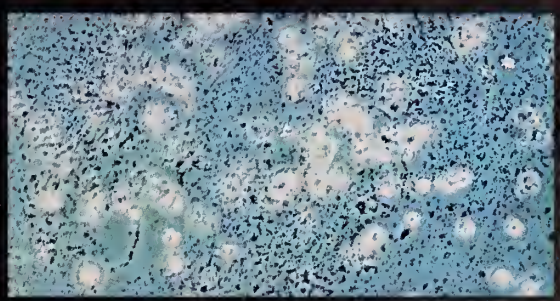


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

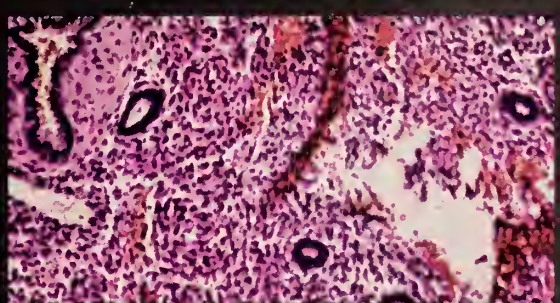
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1 tablets
(norethindrone 1mg. c mestranol 0.05mg.)

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

Night Leg Cramps . . . Unwelcome Bedfellow

In Diabetes[1], Arthritis[2], and Peripheral Vascular Disorders[2]



now . . . specific therapy for night leg cramps

Walker

QUINAMM™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A

PREVAILING FEE PROGRAM

Doctor:

If you have received your personal Schedule of Fees, and your invitation to participate in Prevailing Fee, please check your Schedule for any errors or omissions. Check your Specialty Code for accuracy. (This is the two-digit number appearing below your Taxpayer Identifying Number, which should be checked against the Specialty Code list recently sent you by the Plan.)

If there are any discrepancies in your Fees or Specialty Code, return your Schedule with a letter explaining them; do **not** alter the printed Schedule, as we must enter any changes in computerized records. A corrected Schedule will be sent you promptly.

If your Schedule is in order, sign the Special Participating Doctor Agreement, and return to the Plan, together with one copy of the Schedule with each page signed.

If you submitted a schedule of your usual charges in the Plan's Survey, but have not yet received your personal Schedule of Fees and invitation to participate in Prevailing Fee, please follow the steps outlined above, when you do receive them.

Should you be among the 25% of physicians who did not respond to the Survey, won't you consider, and submit your usual charges now? If you need another Survey form, just call the Plan's Physician Relations Section (201) 662-2201.

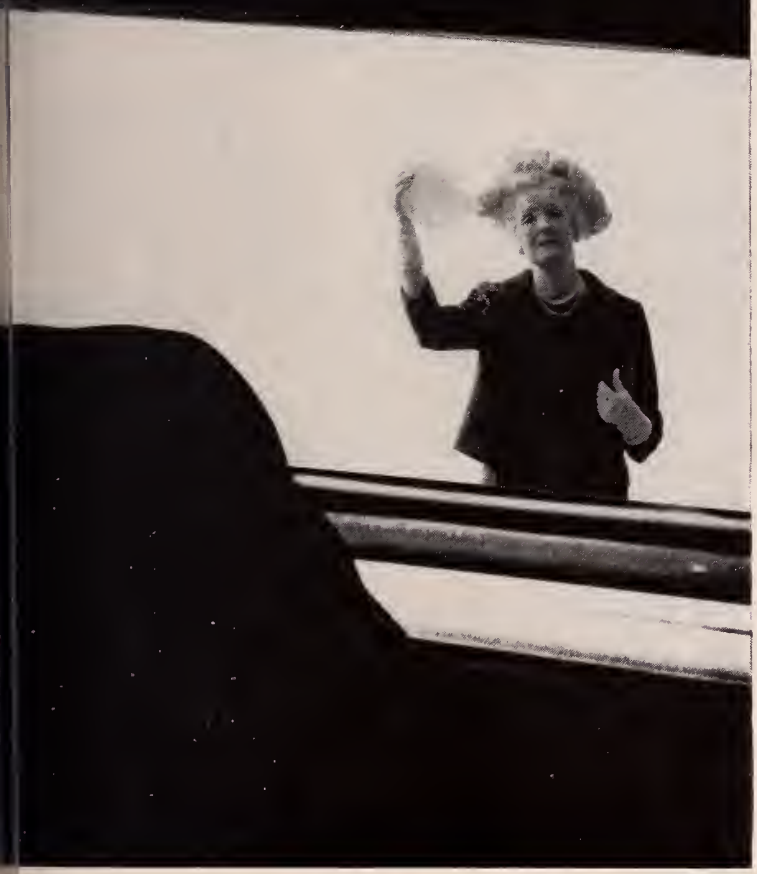
Participation in Prevailing Fee — the advanced method of paying for physicians' services — will be of advantage to yourself, to subscribers enrolled under Prevailing Fee, and to Blue Shield.

BLUE SHIELD
MEDICAL-SURGICAL PLAN ®
OF NEW JERSEY
(New Jersey Blue Shield Plan)
500 Broad Street, Newark



Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyper thyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 ye of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, d turbances of accommodation, swea ing, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and dis orientation), activation of psychosis schizophrenics and agitation (inclu

When a milestone in life is marred by depression...



Often in the mind of the lonely, widowed, depression-prone individual, she's not gaining a daughter...she's losing a son. The occasion may be marred by such symptoms of depression as feelings of sadness, incapacity, helplessness and hopelessness.

In about 3 out of 4 cases, Tofrānil relieves symptoms of primary depression.

As maintenance therapy in primary depressive illness, it helps prevent relapse.

Although toxic reactions severe enough to require discontinuation of Tofrānil are uncommon, in patients with cardiovascular disease, thyroid disorders, increased intraocular pressure, or in those receiving anticholinergics (including antiparkinsonism agents), the special precautions listed in the Prescribing Information should be carefully observed. The use of Tofrānil in patients receiving M.A.O.I.'s is contraindicated.

Tofrānil® imipramine hydrochloride
Geigy

in hypomanic and manic episodes) wch may require dosage reduction a l/or addition of a tranquilizer or te porary discontinuation of the drug, e eptiform seizures, orthostatic h otension and substantial blood p ssure fall in hypertensive patients, p pura, transient jaundice, bone mar- r depression including agranulocy- ts, sensitization and skin rash in uding photosensitization, eosino- p ia, and mild withdrawal symptoms o sudden discontinuation after pro- ld ged treatment with high doses. C casional hormonal effects (im- p ence, decreased libido, and estro- g ic effects) may be observed. A pine-like effects may be more p nounced (e.g. paralytic ileus) in s ceptible patients and in those u g anticholinergic agents (includ- ir antiparkinsonism drugs).
C patient Adult Dosage: Initially, 7 ng. daily, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
Availability: Tofrānil: Round tablets of 25 and 50 mg.; triangular tablets of 10 mg. for geriatric and adolescent use; and ampuls, each containing 25 mg. in 2 cc. for I.M. administration.
(B)46-850-C
For complete details, please refer to the full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502



"Upper respiratory infection! I thought everything was a 'virus' these days?"

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® in two different tablet formulations.

And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

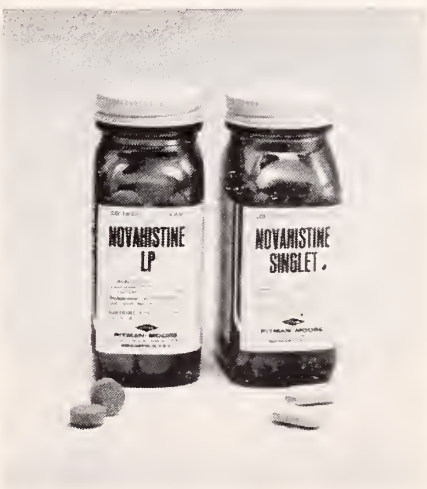
Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.

Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.



DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS



when he just can't sleep

Tuinal

One-Half Sodium Amobarbital an
One-Half Sodium Secobarbit
supplied in ¾, 1½, and 3-grain Pulvule



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206

Lilly

800865

IMPORTANT FACTS

about

Professional Liability Coverage

Insurance that only covers claims based on the rendering of, or failure to render, professional services, or arising out of malpractice error or mistake in rendering professional services, is no longer adequate.

Our policy, approved and recommended by The Medical Society of New Jersey is broad enough to cover:

(1) the non-negligent as well as the negligent claim, such as arising out of duties as committee member in your society or hospital.

(2) The financial loss to a physician in attending trial as a defendant in protracted litigation.

(3) punitive damages for libel or slander.

This program, which was designed with The Medical Society of New Jersey and its legal counsel, and operated by a cooperative Loss Control Program, offers this broad protection, security and continuity of coverage.

Complete protection should not
be controlled by price.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

Professional Liability Department

725 PARK AVENUE EAST ORANGE, NEW JERSEY 07017

William K. Richardson, Acting Manager ORange 3-2575

Home Office: Wakefield, Mass.

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Another safe long term higher yield investment **5%** (PER ANNUM)

PAYABLE AFTER FIRST FOUR DIVIDEND PERIODS.
$1000. MINIMUM BALANCE REQUIRED

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SAVINGS ACCOUNTS

Your safest non-fluctuating investment **4½%** (PER ANNUM)

COMPOUNDED AND PAYABLE QUARTERLY

"Let Your Money Work for You Here"

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Blessed event?

Not entirely, when nausea and vomiting occur in early pregnancy.

Emetrol offers prompt and safe relief. Local rather than systemic action provides emesis control on contact with the hyperactive G.I. tract.* In a study of 123 pregnant women, the drug produced measurable improvement in 79% of patients in controlling vomiting.[1]

*As shown by *in vitro* studies.
1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



Emetrol®
phosphorated carbohydrate solution
emesis control

ROHER WILLIAM H. RORER, INC.
Fort Washington, Pa.


in moderate hypertension and
poorly controlled mild hypertension
(when diuretics or sedatives are inadequate, for example)

When your patients expect a lot...

like relief from hypertensive symptoms
(headache, fatigue, nervousness, palpitation or insomnia, for example)

like an up-to-date, once-a-day dosage schedule
(a schedule not unlike timed-release medication, for example)

like a daily dose of medication for peanuts
(at 10¢ a tablet, for example)

like generally well-tolerated therapy
(as described in the package insert, for example)

...give them a little
(one tablet daily)

Regroton®

chlorthalidone 50 mg., reserpine 0.25 mg.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Regroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-B
For details, see complete Prescribing Information.

Geigy Pharmaceuticals, Division of
Geigy Chemical Corporation, Ardsley, N.Y.

Geigy

"Prescribe With Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

Barefoot Freedom

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR FOR MEN - WOMEN - CHILDREN
OUTFLAIR SHOES FOR CLUB FEET

69 WESTWOOD AVENUE
WESTWOOD, N. J.

350 MAIN STREET
HACKENSACK, N. J.

Dennis Brown Splints — In all sizes — Carried in stock
CUSTOM SHOE SHOP ON PREMISES

in the treatment of
IMPOTENCE



Android®
(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY
ANDROID — GOOD TO EXCELLENT 75%
PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android
Each yellow tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 10 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY
Each red tablet contains:
Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY
Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (¼ gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
Glutamic Acid . . . . . 100 mg.
Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 . . . . . 2.5 mcg.
Riboflavin . . . . . 5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

REFER TO PDR

also available with ESTROGEN

Android-E
Each Tablet Contains:
Methyl Testosterone . . . . . 2.5 mg
Ethinyl Estradiol . . . . . 0.02 mg
Thyroid Ext. (1/6 gr.) . . . . . 10 mg
Thiamine Hydrochloride . . . . 10 mg
Glutamic Acid . . . . . 50 mg

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS** In the female, excessive dosage may produce virilizing effects of most androgens hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.



Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A·H·ROBINS



n sinusitis, colds, U.R.I.
Dimetapp® Extentabs®

(metane® [brompheniramine maleate], 12 mg.;
enylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

p to 10-12 hours clear reathing on one tablet

If hypothyroidism leaves your patient feeling like this...

consider

LETTER®

(SODIUM LEVOTHYROXINE, ARMOUR) TABLETS

Synthetic Thyroid Replacement Therapy



Letter® provides all the advantages of the synthetically pure chemical sodium levothyroxine. Dosage is precise and potency is consistently uniform.

and

Letter® is micronized to provide maximum opportunity for full absorption and clinical response.

In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

ARMOUR PHARMACEUTICAL COMPANY • CHICAGO, ILLINOIS

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SUMMIT, NEW JERSEY

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AN 85 BED INTENSIVE TREATMENT PSYCHIATRIC UNIT

Certified by
The Joint Commissian an Accreditation of Haspitals
The Central Inspection Board, American Psychiatric Assn.







Include MILK *in your* LOW-SALT DIETS

It's no longer necessary to deny patients fresh, fluid palatable Milk in low-salt diets. Walker-Gordon fresh Lo-Sodium Milk (Certified Milk with 90% of Sodium removed) contains less than 50 mg. Sodium per quart. *Guaranteed free of antibiotic residue.* Paper half-pints for hospitals, quart bottles for home delivery. Write or phone for literature, low-sodium diet sheets, and professional sample.

WALKER-GORDON *Fresh* **LO-SODIUM MILK**

Walker-Gordon Certified Milk Farm, Plainsboro, N. J. ★ (609) 799-1234

New York: (212) WAlker 5-7464 ☆ **Philadelphia: (215) MArket 7-6338**

Also Certified Raw, Homogenized-Vitamin D, and Skimmed Milks; available through leading Milk Dealers or call Walker-Gordon

Diarrhea

TROCINATE® 400 MG.

BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

~

WM. P. POYTHRESS & CO., INC.
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Manufacturers of ethical pharmaceuticals since 1856

Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®. Glyceryl guaiacolate, 50 mg., Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

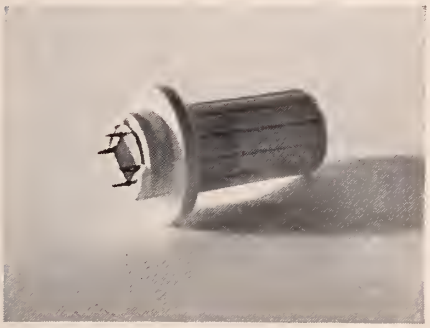
A·H·ROBINS

FIGHT CANCER

AMERICAN CANCER SOCIETY®

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN, TINE TEST
(Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330—8/6135

exercise & ARLIDIN® (NYLIDRIN HCl)



mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Dear Doctor:

Wouldn't you like your patients to learn more about the contributions made by the world of medicine to their welfare? So that they can better appreciate the efforts of the health team to keep them in good health?

To tell the stories of medical and pharmaceutical advances to people throughout the country, the Pharmaceutical Manufacturers Association is sponsoring a unique "magazine within a magazine." It is called *Medicines and your family's health* and the first issue appears in the November *Reader's Digest*.

We would like to send you 50 free reprints o *Medicines and your family's health* for use in you reception room. Your patients will find the articl in this issue factual, educational and of immedia personal interest.

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Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persits for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

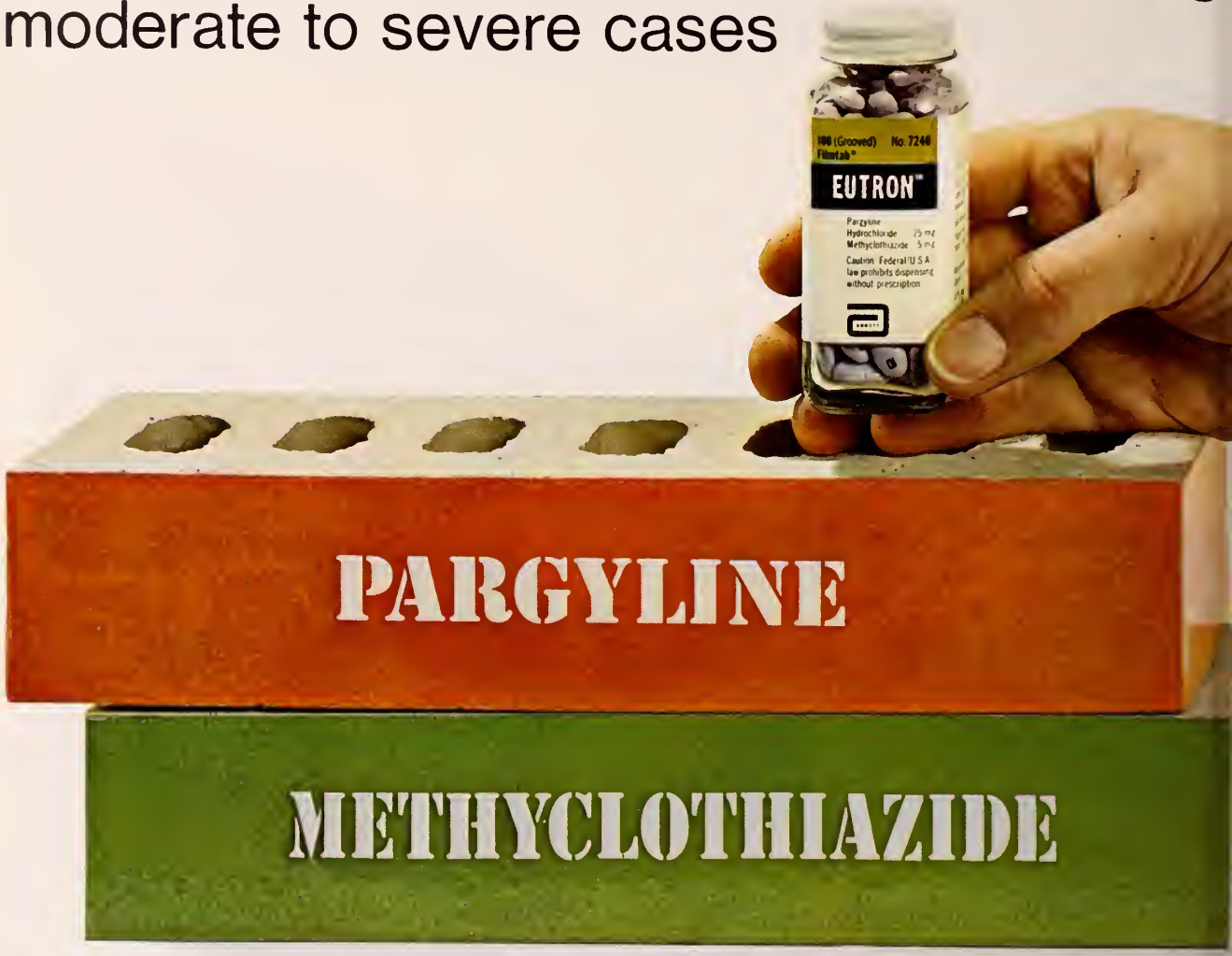
)nce a day, every day
ENDURONYL®
ETHYCLOTHIAZIDE 5 mg. with
SERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amendable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅓ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

801438

ABBOTT

TM-TRADEMARK

Sustained circulatory, respiratory and cerebral stimulation for the

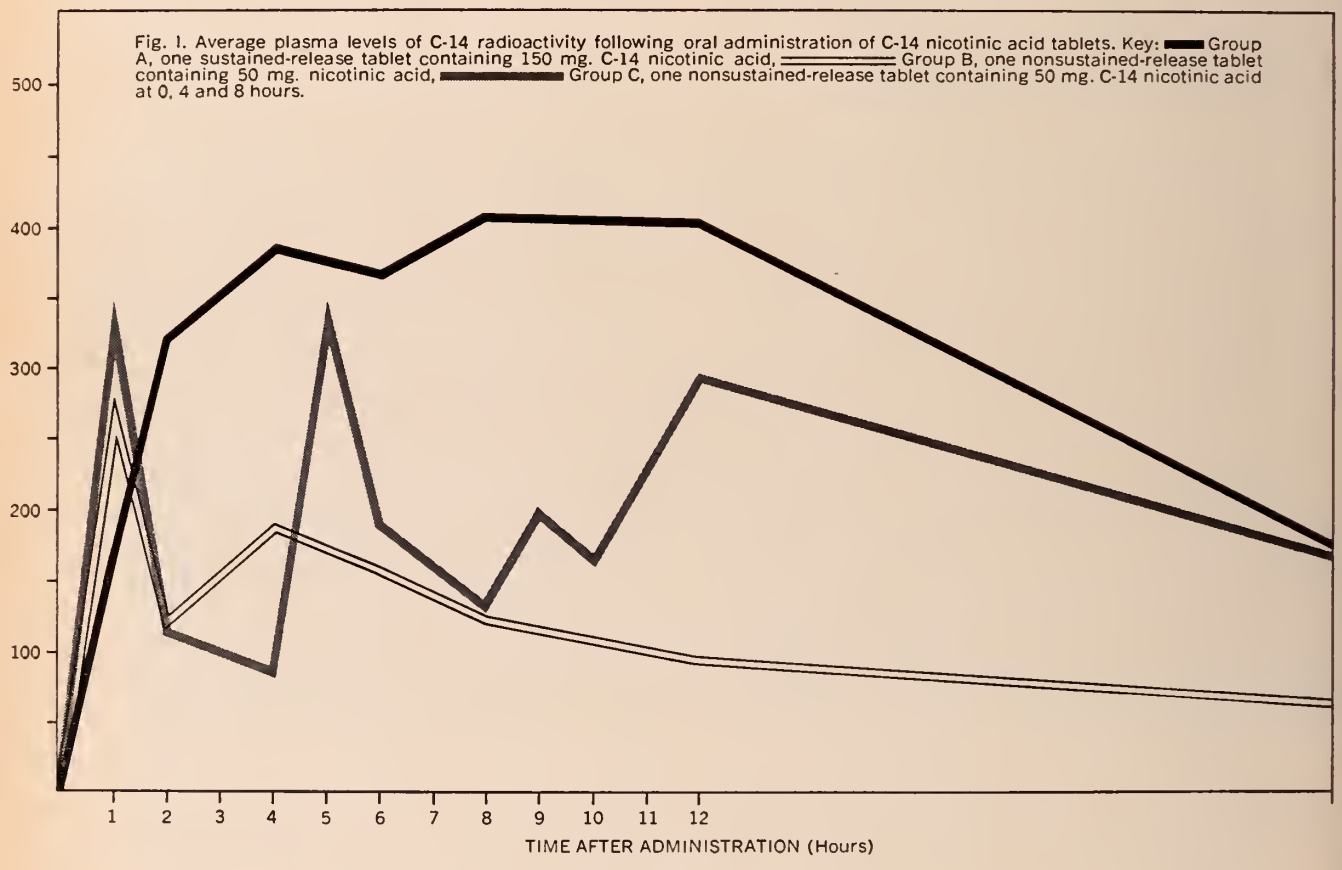


Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.



(fewer absent doses by absent-minded patients)

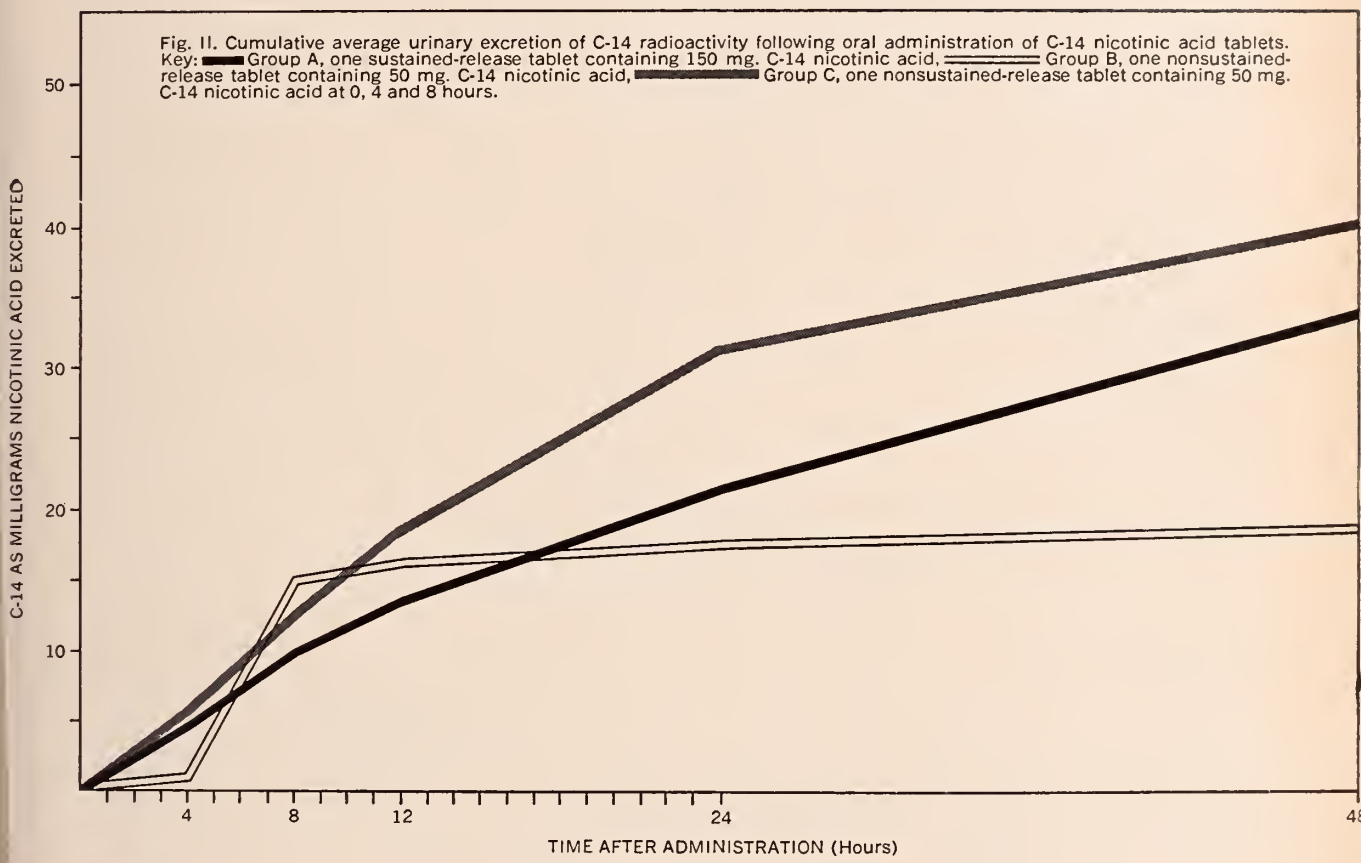
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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EDITORIALS

The Seven Faces Of Truth

Every doctor is tormented by the problem of truth. To tell the doomed patient the truth is to open Pandora's box and let hope, its last blessing, fly away. To deny the truth is hard on the doctor's conscience. So each practitioner, faced with a patient who is permanently disabled or whose days are numbered, has to work out some answer to this question of truth.

But truth has many faces. Its good face is well known to all. The nobility of truth, the propriety of truth-telling are stereotypes in every code. Less well known are the seven harsher faces of truth.

Truth can be pointless. Only an obsessional neurotic believes that if you know all, you must tell all. Unfortunately a doctor *can* be an obsessional neurotic. Would you tell a patient that his protein-bound blood iodine is 11 micrograms? Here is a fact he cannot understand, but one which wears the noble cloak of truth. There is the symptomless diverticulum, the invisible, meaningless congenital spinal anomaly, the functional heart murmur —all of these findings, the stock-in-trade of the quack and cultist. Truth they are, but pointless truth.

Truth can be a bludgeon. Tell a psychotic patient that he is going to be locked in a closed ward, and watch him depersonalize. Tell a patient that his illness is malignant and watch him lose hope and faith. "Blunt truths," as Pope said in his *Essay on Criticism*, "are more mischievous than nice falsehoods." Some truths cannot be told gently, for their very existence may be a harshness.

Truth can worsen disease. Anxiety aggravates disease not only psychologically but also physiologically. Truth can produce anxiety. But it is never the doctor's duty to make disease worse.

Truth can make life unlivable. A child does not become "civilized" until he stops telling the naked truth. To say "I'm glad to see you" is a harmless greeting which indexes a civilized man, though it is often an untruth. The usages of polite society are erected on a substructure of white lies. If lying is sin, we all sin every day, for the pleasant fib is the oil which lubricates the social machine. When your 5-year old goes to his first party, you tell him to be sure to say "I've had a nice time," or "it was a lovely party," as he says "goodbye" to his hostess. If he told the truth, he would be considered an unmannerly brat. Life would be unlivable, if we all went around telling nothing but the truth.

Truth can be a power-tool. He who possesses the truth can use it like a whip to make his victim cringe. In telling an unpleasant truth, the teller may hide behind a facade of virtue. His unconscious motive may be far less noble, for this possession gives him power to hurt others. It is a tempting outlet for the unrecognized sadist.

Truth can be error. Elbert Hubbard once said, "truth is the imaginary line which divides error into two parts." Every honest doctor has had the experience of making an erroneous diagnosis in the best of faith on the best of evidence. Each of us has seen the apparently hopeless patient live on for years—either because of some inner resource or because of a simple diagnostic mistake.

Truth can be therapy—or counter-therapy. What is the doctor's job? To effect his *own* peace of mind and salve his own conscience? To carry the torch for abstract truth? Or to help the patient? When the first two activities interfere with the third, they must be sacrificed for the physician's number one obligation: to solace the patient. Sometimes telling the truth aids in recovery. But if the truth is brutal, it is more likely to hurt the patient. Truth is a precision instrument with a two-way stretch. Whatever is good therapy is the desideratum. If truth drains out of the patient all his will-to-live, then a fig on truth! If only small doses of truth may be tolerated without

panic, then truth must be prescribed in small doses. Always to solace, never to harm, are the basic component's of the good doctor's credo.

As Chancellor Bruce has put it: "Truth may be loved unwisely, pursued too keenly, cost too much." And, as Gonzalo said in *The Tempest* (II, 1):

"My lord Sebastian,
The truth you speak doth lack some gentleness
And time to speak it in. You rub the sore,
When you should bring the plaster."

The Clinician As A Researcher

The word "research" conjurs images of a chrome-plated laboratory filled with electronic gadgets attended by white-coated physiologists, technicians, and engineers. And, in truth *basic* medical research does require the laboratory. Basic medical research seeks to unlock the secrets of physiology, body chemistry, tissue pathology, and the like. It deals, in a sense, with pre-human processes—or at least with processes common to all living matter. Its familiars are the kymograph and the guinea pig. The day has passed when a lone researcher in attic or cellar, using home-made equipment, spark-plugged only by his own genius, could pry Nature loose from some of her secrets. Basic research today requires a team and a work room.

Clinical research is different. It is, in a way, a by-product of diagnostic or treatment methods. You collect many cases of this and notice that most of them have a certain finding in common. You give this drug or that to so many patients and note these good results and these side effects. But the basic building block of clinical research is the individual case report. When the groundwork for modern medicine was being laid in the nineteenth century, the medical literature was filled with individual case reports—a strange case of that, an unusual case of this. In our present mass-production culture, the individual case report looks wistful. Yet it remains, the indispensable architectural unit of medical progress. Follow back the chain from any major medical observation today and eventually you come to the tap root, the "first reported case."

The laboratory is not the only area of research. The library is one and the sick-room is the third. The "library" includes not only the indexed medical journals, but also the hospital record library. With its careful cross-indexing of diseases and complications, it furnishes a gold mine of data for the one who had patience enough to dig in the mine. Stored in the file cabinets and index records of 7000 hospitals in this country are answers to many medical mysteries, awaiting only the curious doctor willing to shape a key to fit the lock. Buried in these archives are records of millions of patients (some 200 million discharges in the past decade alone). What a wealth of material lies here for the one who will take the trouble to till the field! And in the medical journals that pour from the presses are recorded a myriad of facts and fantasies for the researcher. Here you will find if any one else has had a case like yours and what he thought of it.

And then there is the therapeutic trial itself. You can try the proposed procedure or medication and see what it does for the patient. You can note results, and have a mathematically sophisticated friend apply the statistical formulae needed to make sure the results weren't due to change. (Don't omit this step, or your conclusions will lack validity.) You can fix all factors except the one of treatment, to make sure that differences were due only to the treatment program. You can use a double-blind technic to eliminate the emotional effect. And then, without any electronic equipment or chromium cabinets, you are doing research.

Some of the most eminent pioneers in medical research were clinicians. There is, of course, the imperative of time. But busy men somehow manage to find time for important things.

Stockpiling Human Parts

With the modern Stokes freeze-drying unit* you can now stock-pile arteries for grafting. We already have facilities for stocking an inventory of blood, eyes, and skin. It should not be long before we can accumulate stock-piles of kidneys and livers. And just around the corner is the final triumph of all, a stock-pile of brains.

The mechanistic principle — the thesis that the human body is but a machine — is well illustrated in this concept which implies that the practice of medicine is largely a matter of finding the right spare part to fit in. Unfortunately — or maybe most fortunately — the human body is not just a machine. The one disease entity which is most threatening to life today is the chronic ailment. The one which produces the greatest disability is mental disorder. These are not well understood, if they are visualized only as mechanical breakdowns. The human body may be a machine, but it is a machine haunted by a spirit — sometimes a mean spirit, but often enough a noble one. And an evermounting stock-pile of spare parts has little to offer the ghost in this machine. But it is this ghost which pulls the levels after all.

Medical Realism Invades The Living Room

The television screen is more sensitive to possible obscenities than is the stage or even the moving pictures. The reason is obvious. You can keep your children from the movies or from the theatre. But, you cannot keep them from the living room. (Sometimes, in fact, it is even called a "television room" as if television has become a synonym of living.) In a way, television has a captive audience. To be sure, there is always the greatest TV gimmick ever invented: the knob for turning it off. But if the TV drama morbidly magnetizes an immature auditor the viewer is *not* going to turn it off.

There are numerous organizations — religious, civic, judicial, and educational — interested in protecting the living room against obscenities on the TV screen. No one, however, seems concerned with the invasion of the living room by medical details which produce a fascinated disgust, a gruesomely sadistic reaction, or an acute hypochondriasis, according to the auditor's temperament. It used to be said, half in jest, that the medical student would think he had each disease he studied. It can certainly be said, not at all in jest, that a less sophisticated audience than a group of medical students is going to identify with the patient in the TV drama. Since script writers prefer the rarer and less pleasant disease, the viewers are now getting frightened by a choice battery of obscure but deadly illnesses. When delivering a baby becomes a TV spectacle, the more naive pregnant woman begins to worry about possible complications of labor. When bleeding is portrayed as a sign of hemophilia, every viewer is frightened by a cut finger.

Many people are — believe it or not — revolted at seeing such things as a pulsating human heart, a fresh placenta, or an avulsed tongue. Yet the arm is frozen in fascinated paralysis when it comes to turning off that knob. Also, the hammed-up air of drama which pervades TV hospitals is unfortunate. When a patient actually enters a hospital, he is vastly disappointed, because it does not conform to the script writer's picture of it. And similarly when his private family doctor fails to measure up to Dr. Kildare, there is disillusion.

To be sure, the public has a right to know about medicine. The healthy way to do this would be to dispense that knowledge as the occasion arises, balancing it in proportion to the frequency or importance of the specific subject. Knowledge can be dispensed with balance, restraint, and accuracy so that it does not mislead, does not pander to morbid tastes, and does not make hypochondriacs out of the hearers.

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* F. J. Stokes Machines Company, Philadelphia. Appropriately, it is a *machine* company which entered this field.

ORIGINAL ARTICLES

Here in a few words, our President offers the business community a doctor's view of federal involvement in health matters

The Bitter Pill Of Uncle Sam*

Louis K. Collins, M.D./Glassboro

The title of this talk may appear that as a physician, I am prejudiced. Well, perhaps I am. However, I feel that this Government pill is, or will become, just as bitter to you, the taxpayer, as it is distasteful to most practitioners of medicine.

First, let me discuss the statute which is probably most familiar to you: Title 18, the Medicare Law. Many of you have already had experience with this monstrosity, with its "deductibles," its mixing of Part A and B coverage in hospitals, either as in-patients or out-patients, assignment and non-assignment, receipted bills, and so on. How do you younger wage earners like to subsidize millionaires who are utilizing the benefits of Medicare? Now, there are proposed increases in Social Security taxes to help pay for this wasteful and expensive scheme. One problem for the well-to-do senior citizen who does not prefer to use Medicare, is that he cannot purchase regular Blue Cross and Blue Shield policies. The available supplemental Blue contracts must be used in conjunction with Medicare. There are bills pending in Congress to modify, and we hope, to clarify some of the provisions of the Medicare Law. The Medical Society supports this clarification. However, we still feel that it is a bad and unpalatable law that promised much, costs much more than the proponents had forecasted, and has disappointed many of our elderly sick people.

Title 19 is the so-called "Medicaid," which is a modification and extension of the Kerr-Mills Law, which the American Medical Association supported. This passed Congress with very little notice and fanfare as it was appended to the Medicare legislation. It has the potential of becoming even a greater threat to the freedom of the practice of medicine, and promises a much deeper grab into your pocketbook. This law must be in operation in all states by 1970, and must include at least the five following parts: (1) Old Age Assistance; (2) Aid for Dependent Children; (3) Aid for the Blind; (4) Aid for the Permanently Disabled; and (5) Medical Assistance for the Aged. By 1975, all medically needy must be fully covered for *all* medical and hospital services. There will be no income ceiling for these five programs. Any participants between ages 21 and 65 must be categorically "needy." This has been the hitch in many state's plans — too liberal an income ceiling, which seemingly could almost bankrupt some states. The matching formula for State and Federal funds varies with the different states; 25 to 50 per cent for the states, with New Jersey in the highest bracket (50 per cent) as we are supposedly one of the "richest." There is no definite provision for it in the Federal law, but most states permit free choice of doctor and hospital, and usual and customary fees. We in The Medical Society of New Jersey are working closely with the Commissioner of Institutions and Agencies and with the Legislature to establish a fair and workable format for New Jersey. The most reasonable estimate of the cost to the state is over 100 million per year at the beginning.

The third federal law in this area is Public

* Talk to the Kiwanis Club of Hammonton, New Jersey on August 22, 1967.

Law 89-239, the Heart, Stroke, and Cancer Amendment. The State Committee in New Jersey, in May 1967, was awarded $297,000 for a planning grant. The Greater Delaware Valley Regional Program has been granted 1.3 million. We intend to work earnestly and, I trust, harmoniously with both groups in South Jersey. There are several facets to this legislation:

1. Continuing education of physicians, nurses, technicians, and other ancillary personnel by several methods including television, radio, tapes, seminars, and advanced training courses.

2. Discovering areas of need in patient care; prevention and treatment; gathering statistics; hospital capabilities and limitations. There probably will be planning for major treatment areas for victims of cancer, stroke, heart, and related diseases. The Health Facilities Planning Council may be asked to help outline the needs, and endeavor to prevent costly duplication of such facilities as cobalt bombs, open heart surgery, organ transplants, and the like. Another important sector is the development of and continued training of personnel to staff these important life-saving hospital units.

Now consider Public Law 89-749: Comprehensive Health Planning and Public Health Service Amendments of 1966. Each state has a federal grant administered by the State Department of Health. This concept is rather vague at present, but we have been in touch with Dr. Kandle, and plan further conferences before definite plans are formulated.

Many of the really important health needs of the community can be served best by cooperation with local volunteer agencies, such as the Heart and Cancer Societies, local Mental Health units, PTA's, Chambers of Commerce, Service Clubs, Visiting Nurse Associations, and County Homemaker Services. Not only doctors and allied personnel, but all citizens should become interested in, and work for and with, these dedicated groups. We should all try to see that our tax monies are not wasted. These volunteer organizations can, better than Uncle Sam, learn the needs of the community in health fields, and lead the way toward remedial action. Federal funds will be necessary and available, but let us show the national government how to expend them wisely. Just because each state gets so much money, is no reason to throw it to the winds.

If you don't like the way these federal funds are being allocated and utilized, write to your congressman — Election Day comes again this fall.

In conclusion I should like to quote a full page advertisement in a non-medical magazine, by Warner and Swasey — Precision Machinery, Cleveland.

Indigestion

Twenty-one different Federal health programs: 17 for education, 15 for economic development, 12 on urban crises, 4 for manpower training, 17 on natural resources. Billions from 400 separate appropriations are being spent on 170 programs administered by 21 departments, 150 bureaus.

And is the nation actually any better educated, any healthier, are there any fewer crises?

It's the deadening American epidemic of "Spend the Money" — the false idea that you can cure something evil just by appropriating money.

When will we learn the inescapable fact that health, education, character, security can come only from self-denial and hard work and intelligence — never from merely spending money?

54 State Street

For Your Traveling Patient

The United States Public Health Service has now issued a new edition of its manual on immunization information for foreign travel. This is an updated revision of a booklet which, in some detail, tells about the documents and immunization required for foreign travel — what country would require what immunization. It gives information on importation of pets and much other data. For your copy, send 40¢ to the Superintendent of Documents, Washington, D.C. 20402, and ask for Public Health Publication #384.

This fact-finding survey emphasizes the need for accident prevention as a primary function of every physician.

Childhood Accidents*

A Study of 8,700 Medically Attended Accidental Injuries in New Jersey Children.

William J. Farley, M.D./Nutley
and
Samuel C. Southard, M.D./Ventnor City

A survey was recently made by the Committee on Accident Prevention of the New Jersey Chapter of the American Academy of Pediatrics. Its aim was to keep the problem of accidental injury before its members and to encourage preventive guidance in their practice and in their community. This tabulation and review of the toll of injured children should be instructive and impressive. Of course, much factual information on all types of accidents recorded directly from pediatric practice was not available.

To permit the participation of as many individuals as possible in the survey and to augment the number of subjects studied, it was decided to include a survey of children treated in the emergency rooms and admitted to the hospitals of New Jersey during the same period. This, likewise, should be instructive to the hospital house staff and nursing personnel and alert them to the problems in their own community. This project was inaugurated as an educational device with the hope that worthwhile data might also be obtained. After a careful review of this program, the Committee considered it worthy of a published report and the basis of an exhibit for presentation at medical meetings. The exhibit entitled "What's Your C. A. I. Q. (Childhood Accident Intelligence Quotient) Doctor," was presented at the Annual Meeting of the American Academy of Pediatrics in October, 1964, at The Medical Society of New Jersey in May, 1965 and at the 1966 Morris County Health Fair. Figure 1 is a composite photograph of the exhibit.

Methods of Study

On March 1, 1962 a letter was sent to 183 New Jersey Fellows of the American Academy of Pediatrics asking them to maintain a record of all accidental injuries treated in their practice during April, 1962. A tally sheet for entry of each accident was enclosed which included information concerning the child's age, the type of accident, and the disposition or management of the case. At the same time, a letter was sent to the Chief of the Pediatric Service of all hospitals in New Jersey with over 100 beds requesting a similar tally of accidental injuries of children, age 15 and under, treated in the hospital emergency room or dispensary during the entire month of April, 1962.

Upon receipt of the tally sheets, each accidental injury in each individual report was coded according to the classification outlined in Figure 2. The pediatric practice reports and emergency room reports were tabulated separately. In turn, a separate study was also made of injured children admitted to the hospital during this one month.

Figure 3 shows the number of pediatricians and hospitals to which letters were sent, those replying, and the total number of children in each survey. Figure 4 lists each hospital re-

* Dr. Farley is a former chairman of the Committee on Accident Prevention of the New Jersey Chapter of the American Academy of Pediatrics. Dr. Southard is a former chairman of the National Committee on Accident Prevention of the American Academy of Pediatrics.



Figure 1

plying and the number of accident cases treated.

FIGURE 2
ACCIDENT CLASSIFICATION AND CODE

1. According to diagnosis
   - L = Laceration
   - C = Contusion
   - F = Fracture or Dislocation
   - I = Poisoning or Ingestion
   - P = Puncture Wound
   - S = Sprain
   - B = Burn
   - FB = Foreign Body
     - s = Stomach
     - n = Nose
     - ey = Eye
     - e = Ear
     - t = Esophagus
     - r = Respiratory Tract

2. According to location
   - f = Head
   - f — = Face
   - h = Upper Extremity (Including Shoulder Girdle)
   - h — = Hand
   - l = Lower Extremity
   - t = Trunk (Including Neck and Pelvis)

3. According to manner of injury
   - fa = Fall or Collision
   - th = Thrown or Moving Object
   - cu = Cutting or Sharp Object
   - an = Animal Bite
   - cr = Crushing
   - bi = Bicycle
   - mo = Motor Vehicle

4. Disposition
   - R = Referred elsewhere
   - H = Hospitalized
   - D = Death

Analysis of Accidental Injuries

A tabulation was made of the total experience according to clinical diagnosis; manner of injury — agent or cause; and the site of injury or part of body involved. This is presented in Tables 1, 2 and 3.

Review of the reports also revealed that:

1. Aspirin, as usual, was the most frequently ingested potential poison with 33 per cent poisonings attended in practice.

2. The clavicle was the bone most often fractured and attended in practice, totaling 34 per cent. The head of the radius was the joint most often dislocated.

3. Puncture wounds treated in the emergency room occurred in the foot in at least 51 per cent. Of these, 84 per cent were reported as having "stepped on a nail" usually "rusty."

4. Of the total number of children hospitalized from pediatric practice, 60 per cent suffered a head injury. Of these, 90 per cent were suspected of having a cerebral concussion. Of those admitted from the emergency room, 40 per cent sustained a head injury and

FIGURE 3

A. Survey of Pediatricians in Active Practice

Total Number of Pediatricians from Whom Reports Were Requested	183
Number of Reports Returned	125
Replying (Per cent)	68%
Children in Survey	2,016
Average per physician	16

B. Survey of New Jersey Hospitals (Over 100 Beds)

Total Number of Hospitals Queried	58
Reports Returned	33
Replying (Per cent)	57%
Children in Survey	6,684
Average per Hospital	203

FIGURE 4

HOSPITAL CHILD ACCIDENT SURVEY
April 1962

Atlantic City	256
Clara Maass	192
Elizabeth General	178
Englewood	287
Hunterdon Medical Center	75
Hackensack	245
Jersey City Medical Center	394
Monmouth Medical Center	170
Mountainside	235
Morristown Memorial	195
Babies	142
Martland Medical Center	468
St. Michael's	135
Middlesex General	125
Newton Memorial	66
St. Mary's (Orange)	138
Passaic General	196
Beth Israel (Passaic)	132
St. Mary's (Passaic)	102
St. Joseph	23
Perth Amboy	270
Muhlenberg	415
Chilton Memorial	202
Princeton	111
Rahway	154
Valley	257
Salem Memorial	65
Somerset	205
Overlook	211
Holy Name	270
Mercer	251
Pascack Valley	194
Community (Toms River)	64
Total Accidents	6684

78 per cent of these were suspected of cerebral concussion.

Disposition of Injured Children

It was requested that the participating physician report all injuries encountered in their practice that were treated solely over the telephone. Eleven physicians accurately recorded and reported this. An average of 22 per cent of their accident cases, with a range of 10 to 30 per cent were treated by phone.

Some 8 per cent of the children in the practice study were referred elsewhere for further care. Fifty-one children were sent to other physicians and 103 to the hospital emergency room. About 2 per cent of the 2,016 children in the practice study were hospitalized. About 6 per cent of the 6,684 children reported from the hospital emergency room were admitted as in-patients. This latter group of hospitalized children were studied and are included in Tables 1 and 2.

Four deaths (from the total 8,700 children studied) were reported. Here is a summary of the four fatal cases:

14 months—fall from bathinette, cerebral hemorrhage.

5 months — suffocated in crib by plastic bib; dead on arrival.

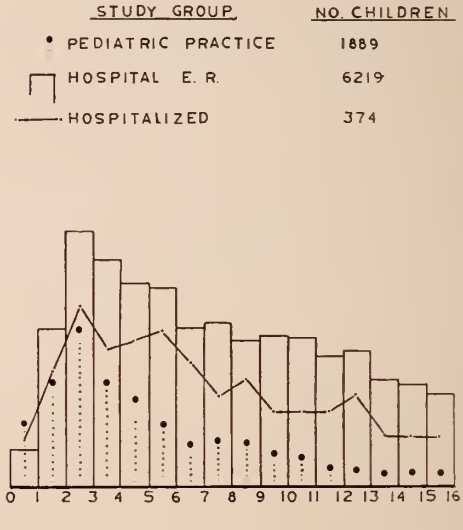
3 years — motor vehicle accident; cerebral laceration.

8 years — motor vehicle accident; dead on arrival.

GRAPH 1

RELATIVE AGE DISTRIBUTION

ACCIDENTAL INJURIES IN CHILDHOOD



The relative age distribution of all children reported in each study group is presented in Graph 1. Peak incidence for each study group was age two to three. Each graph represents the proportionate number of injured children at each age and is strikingly similar.

TABLE 1—CLINICAL DIAGNOSIS

Diagnosis	Pediatric Practice		Hospital Emergrncy Room		Hospitalized Children	
	No.	%	No.	%	No.	%
Laceration	749	40	2,369	41	34	12
Contusion	555	31	1,874	30	98	35
Poisoning or Ingestion	157	8	282	5	26	8
Fracture or Dislocation	116	6	456	8	86	34
Puncture Wound	89	5	389	7	9	3
Foreign Body	79	4	220	4	11	4
Sprain	64	3	162	3	1	0
Burn	59	3	126	2	13	4
TOTAL REPORTED	1,868	100%	5,878	100%	278	100%

TABLE 2—MANNER OF INJURY (AGENT OR CAUSE)

Manner of Injury	Pediatric Practice		Hospital Emergency Room		Hospitalized Children	
	No.	%	No.	%	No.	%
Fall or collision	873	48	1,730	36	104	41
Cutting—sharp object	172	9	734	15	20	8
Moving or thrown object	164	9	470	10	12	5
*Poisoning or Ingestion	157	9	282	6	26	10
Animal bite	120	7	370	8	0	0
Crushing	100	5	393	8	3	1
*Foreign body	79	4	220	5	11	4
*Burn	59	3	126	2	13	5
Bicycle	54	3	208	4	20	4
Motor vehicle	51	3	297	6	45	18
TOTAL REPORTED	1,829	100%	4,841	100%	254	100%

*Also included in Tabulation According to Diagnosis.

TABLE 3—SITE OF INJURY (PART OF BODY INVOLVED)

Total External Injuries	Pediatric Practice			Hospital Energency Room		
	No.		%	No.		%
Head	886		56	2,084		43
Face		(551)	(63)		(1,285)	(60)
Upper Extremity	423		27	1,658		34
Hand		(315)	(74)		(978)	(62)
Lower Extremity	222		14	946		19
Trunk	46		3	182		4
TOTAL REPORTED	1,577		100%	4,870		100%
Fracture or Dislocation						
Upper Extremity	88		76	297		65
Skull	16		14	10		2
Lower Extremity	6		5	94		21
Trunk	6		5	21		5
Others or Unknown	0		0	34		7
TOTAL REPORTED	116		100%	456		100%
Foreign Body						
G. I. Tract	44		56	60		27
Nose	14		18	28		13
Eye	13		16	68		31
Ear	4		5	34		15
Esophagus	4		5	26		12
Respiratory Tract	0		0	4		2
TOTAL REPORTED	79		100%	220		100%

Discussion

This survey was planned to coincide with other educational activities supported by the Committee on Accident Prevention during April, 1962. These activities included a proclamation by Governor Hughes of "Child Safety Week" with its attendant publicity and a campaign for the development of community child safety programs throughout our State.

The unusually large return of reports from our pediatric colleagues (68 per cent) as well as the hospitals (57 per cent) was most gratifying.

The average number of accident cases treated in pediatric practice was 16. This figure included those physicians whose reports were late and seemed incomplete. It is our impression from reviewing each report and from our own experience that the practicing pediatrician attends at least an average of one injury per day and usually more during the summer months.

The survey permitted a comparative analysis of three study groups: those children treated in (1) pediatric practice, (2) the hospital emergency room, and (3) as hospital in-patients. The practice and emergency room survey proved similar in most aspects. Those children hospitalized represented more serious injuries as evidenced by the fewer lacerations and the greater proportion of fractures and injuries by motor vehicles.

Falls and collisions or accidents associated with physical impact caused most injuries resulting in lacerations and contusions. The head and upper extremity were injured most often with the face and hand the leading points of impact. The head, by far, proved to be the most vulnerable part of the body.

In all study groups, the highest incidence of accidents occur in the two to three-year-old-age group. A laceration of the face in a two-year-old sustained in a fall is the most frequent medically attended injury in childhood.

Four deaths were reported in the combined survey, two of them caused by motor vehicles. During April, 1962, the New Jersey State Department of Health reported 33 accidental deaths of children under 15 years of age in New Jersey. One-third of these children were killed in automobile accidents. National Safety Council mortality figures in children indicate that the motor vehicle is the number one cause of accidental death, followed by drownings, burns, falls, firearms, and poisonings, in that order. Well-organized public health measures should cetrainly be directed especially toward these major causes of death and permanent injury.

Some may say that this survey is merely a compilation of trivial and inevitable "happenings" in the normal development of the growing child. It is, however, suggested that even the minor accidental injury may be symptomatic of the failure of adequate supervision or education. Certainly the almost tragic "near-misses" (seen so often in pediatric practice and the emergency room) deserve a careful appraisal, by physicians and parents, of the influential circumstances and possible causative factors surrounding the accident in the home or community.

Effective and meaningful guidance directed toward the prevention of accidental injury cannot best be given in the emotion-packed climate at the time of injury. Such guidance *can* be effectively offered during the regular periodic examination and visit of the well child in the office, clinic, or community health station. Anticipatory guidance must receive as much attention as the auscultation of the chest or the immunization against disease. There is a safety message appropriate for every visit at every age.

322 Chestnut Street

Mental retardation is an area where the physician needs the help of the community team including a well-trained social worker.

Role Of The Community Clinic In Mental Retardation*

Joseph Wortis, M.D./Brooklyn, New York

More than 15 years ago the parents in the newly formed Association for Retarded Children of New York City exerted pressure upon hospitals and the profession to organize community-based clinics for the mentally retarded. These parents were motivated by the hope that such clinics might become the means of diagnosing, treating, or even curing the retarded child. For the most part their expectations were, of course, unrealistic, because only a minority of cases of retardation have diagnosable causes, and very few cases are treatable by conventional medical means. In the mild or borderline cases, social-psychologic factors are common, but there is still a general tendency to gloss over the distinction between the biologic bases of mental retardation and the social-psychologic consequences of an unfavorable environment which constricts the child's capacity to adapt. Nevertheless, these clinics have proved to be helpful in the rehabilitative process, and have become important centers for the development of community services, training, and research.

It is the common statistical practice to project the observational data of any large population in the form of a standard Gaussian curve with extremes at either end, using as a cutoff point two "standard deviations" from the mean to determine the "normal" range. When this method is applied to a large series of IQ determinations, it follows necessarily that the 3 per cent of our population below that cutoff point will be classified as subnormal purely on the basis of a mathematical formula. To state, therefore, that the incidence of mental retardation in this country is 3 per cent obscures the relative weight of biologic factors compared with economic, social, and cultural factors which must be considered in evaluating the true incidence of biologic defect. The history of the Stanford-Binet test itself is its own best argument against the statistical method of evaluating incidence. Binet himself regarded it mainly as a measure of educational accomplishment not as a measure of native endownment. Standards for this test are based entirely on data derived from an all-white population. Knowing what we do of the cultural and other environmental factors which surround the development of the child of Californian-Mexican parents, Negro parents, or Arizonian-Indian parents, we can hardly expect a test based on such standards to provide comparable data on innate intellectual potential. In Miami, for example, Negro children averaged an IQ of 85 on the test. A similar finding was observed in rural parts in Puerto Rico.

A specific cause for mental retardation can be determined in only a small minority of cases, e.g. in cases of phenylketonuria, Hurler's syndrome, Down's syndrome (mongolism),

* Dr. Wortis is Director of Developmental studies at Maimonides Mental Health Center. This paper was part of a symposium on the retarded child held on April 5, 1967 at the Middlesex General Hospital in New Brunswick, New Jersey, under the joint auspices of the Pediatric Society of Central Jersey and the New Jersey Academy of Medicine. This symposium was supported by a grant from Merck, Sharp and Dohme.

congenital galactosemia, and so forth. In the remainder one can usually make only a vague surmise of the cause, particularly if the diagnosis of retardation is based merely on the finding of a low IQ score. At best this can be held to represent only a measure of level of mental development with no indication of its underlying basis.

A biologic defect, even without a specific etiologic diagnosis, can often be suggested by the observations of teachers and other persons responsible for aiding the intellectual progress of the child. Their direct involvement often constitutes sufficient basis for suspecting that "the child is not well put together." On the other hand if their judgment suggests that the child's retardation is largely (or entirely) experiential, the outlook becomes at once much more hopeful.

In a community-based clinic, a retarded child can be given the benefit of speech therapy, neurologic and psychiatric evaluation and care, psychologic testing, and recourse to other facilities. Because of the enormous expense of maintaining such a clinic and the dearth of trained personnel, facilities of that type should be restricted to the care of cases referred from other sources. Screening teams including a psychologist, a physician, and a teacher are or should be available, therefore, for the schools. Once they have determined the likelihood that a problem of severe or complex retardation exists, (or if a medical basis is surmised) the child can be transferred to the specialized clinic for complete workup and further care.

For all these reasons it is clear that a systematic program of regional planning on the part of lay workers and physicians is imperative, if the needs of the retardate in our population are to be met in any effective manner.

Social Work Approaches†

The importance of social and environmental factors as a cause of mental retardation, and the necessity for social planning to prevent retardation and ameliorate the condition of retardates have only recently become a basic part of our thinking, so that the full impact of this knowledge has been felt in but limited degree. Public and voluntary social welfare programs have an important role both in large scale planning and in helping individuals meet the problem of retardation in their own families.

The close relation of prematurity to mental retardation and the association between prematurity and poverty underline the key role of the social worker in the preventive aspects of mental retardation. The association between poverty and prematurity is described in a report by the World Health Organization committe on prematurity which cited many examples of this relationship. In Sweden, with its highly developed program of social welfare, premature births occur in no more than 2 of 100 live births. In our own country the rate is 11 per 100 births. The incidence is higher in certain slum areas in Brooklyn, where it reaches more than 20 per 100. One has only to consider the economic and social burden upon society of mental retardation associated with premature birth to become strongly persuaded of the importance of proper social planning to control the social conditions which are so deleterious to normal development.

A broad program of prevention of mental retardation can justifiably include such social measures as prenatal clinics held in places and at times when working women can use them, the proper prenatal care of unmarried mothers, and particular attention to nutrition of children in low-income families. The prevention of mental retardation associated with the neglect and deprivation of young children is projected by some of the anti-poverty programs of the Federal Government, such as Project Head Start. The social worker may assist in identifying areas of need and in helping plan appropriate programs. But the mere existence of a good program is insufficient. Such programs must be properly

† This section was prepared by Helen Wortis, M.S.

used by the persons who most require help, and the social worker may assist individuals in finding and using the services they need.

In the important area of specialized services to individuals the social worker provides direct assistance to the families of mental retardates in helping them carry the burdens associated with a chronic life-long disability. Experience has shown that these children need many services, if they are to be maintained in the community without undue strain upon their families. In spite of the need there are relatively few schools, nursery schools, or recreation and training centers which can relieve parents of some of their all but intolerable burden.

One of the areas of greatest usefulness of social workers is in providing emotional support and guidance for the parents of handicapped children so that they need not carry the entire responsibility for their care. Without such help, the parent may become a prey to depression and emotional disturbance which undoubtedly creates an even less propitious environment for the retardate. The problem of the parent is, in fact, a central one in all planning for the care of mental retardates. The parents may need guidance and strong support, when they first become aware of the fact that their child is defective and must decide whether to keep the child at home. Later, when they look about for some means of schooling the child, they require additional help. Ultimately, as they approach advanced age their anxiety about the dependent child may develop into a particularly harassing emotional and physical problem. At this stage help in planning is again needed. In all these matters the social worker in the clinic, the school, or the family agency may be called upon for assistance.

Facilities of the required type are far from adequate at present. It is incumbent upon the medical profession to lend its influence and emphatic endorsement to the moves needed to achieve the necessary planning and legislation for these purposes.

152 Hicks Street

Smoking Patterns Of Physicians

The effects of the current anti-smoking campaign on the smoking habits of physicians were studied specifically as related to (1) probable level of familiarity with pathology imputed to smoking as estimated from type of specialty practice, and (2) probable amount of exposure to the campaign as estimated by rural-urban site of practice. A pre-coded questionnaire was mailed to all members of the Oregon Medical Association residing in Oregon in May 1964: 1,790 (90 per cent) usable, completed questionnaires were obtained. The type of medical specialty practice was found to be related to present smoking habit, mention of smoking as a cause of cancer, the number of illnesses attributed to smoking, and the frequency and recency of cessation of smoking; the type of medical practice is not related to the degree of hazard ascribed to smoking or to the stated reason for stopping smoking. The geographical location of an Oregon physician's medical practice is not related to these variables. These and other reported findings suggest that anti-smoking campaigns, by themselves, may produce marked changes in the smoking habits of some individuals but these represent only a rather small minority of the population. To attain more widespread reduction in smoking it will be necessary to employ a broad and diversified array of approaches.

— Weitman, M. and Meighan, S. S.: *Cancer* 20:974 (June 1967)

The magnitude of the problem and its wide geographic coverage make federal help essential in the broad problem of preventing mental deficiency or rehabilitating the defective.

Role Of The Government In Problems Of Mental Deficiency

Gerald Kissin, Ph.D.
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The federal government has long been concerned with mental retardation and with services for prevention and care in this field. These developments have followed the pattern manifested in other such services first, *response to a need.* For example, psychologic testing followed the introduction of compulsory education. The need to predict whether children could be educated, coupled with the inadequacy of teacher judgments for this purpose, gave rise to such instruments as the Stanford-Binet test and the formulation and acceptance of the IQ concept. In this way, a piece of educational legislation gave rise to other legislation and an awareness of the problems and responsibilities presented by mental retardation developed.

As this evolved, the size and heterogeneous nature of the problem made it evident that a broad approach would be necessary. In recognition of this, President Kennedy in 1961 appointed a Panel on Mental Retardation. After two years of activity, this group promulgated its recommendations in its widely-distributed, frequently-quoted publication, *National Action to Combat Mental Retardation.* They felt that the problem of mental retardation required a multi-agency and multi-disciplinary approach if any real services were to be provided. In the public service sector, these recommendations meant the involvement of almost every agency of government. The recommendations included observations and suggestions concerning programs in research, prevention, clinical and medical services, education, vocational rehabilitation, residential care, protection of the retardate's legal rights and privileges, and coordination of federal, state, and local agencies. The Panel gave full recognition to the wide diversity of the needs of the retardate and the special requirements of the growing child, as such.

Program activities resulting from this study and recommendations are beginning to bring added clarification to this problem. If nothing else, we are beginning to doubt some of the myths and stereotypes surrounding retardation. For example, it has become increasingly difficult to speak with confidence of "proved methods" for prevention of biologically determined mental retardation (with some rare exceptions). On the other hand, factors of prevention of the retardation effects of socio-cultural and economic deprivation (which had seldom been considered) are today receiving more consideration.

In all of these, Government support through individual grants and support to the states has encouraged research and demonstration

* Dr. Kissin is the Regional Consultant on Mental Retardation for the U.S. Public Health Service. This presentation was part of a symposium supported by Merck, Sharp and Dohme and sponsored by the New Jersey Academy of Medicine and the Pediatric Society of Central Jersey. Under the chairmanship of Sylvan Moolten, M.D., it was held on April 5, 1967 at the Middlesex General Hospital in New Brunswick, New Jersey.

projects to provide the knowledge and instrumentalities helping to bring about better and more effective services in this field. Among the larger and better known federal programs in this field are the following:

The Children's Bureau and Bureau of Family Services of the U.S. Department of Health, Education, and Welfare provide assistance to state health departments, crippled children agencies, and state welfare agencies for programs designed to increase the health and welfare services for children in that state. In this manner, they make additional services available to the retarded by such means as enlarging existing mental retardation clinics by the addition of staff, by increasing the number of clinics, by extending screening programs, by providing treatment services for physically handicapped, retarded youngsters, by increasing inservice training opportunities in retardation for clinic personnel, and by providing homemaker and other care services for the mentally retarded.

Further, a variety of services to the mentally retarded have been made available through programs supported by the United States Vocational Rehabilitation Administration through the appropriate state agency. These have included support for such activities as medical diagnosis, physical restoration, counseling and testing during the rehabilitation process, assistance in job placement, and follow-up to ensure successful rehabilitation.

In each of the foregoing instances, the services to the mentally retarded have been, generally, supported through the generic programs of these agencies.

The federal agency charged directly with the health concerns for the mentally retarded is the Division of Mental Retardation of the United States Public Health Service, of which I am the representative. Although the areas of direct support are specific and limited by the intent of Congress in making these funds available, the interest and involvement of this Division extends into all aspects and concerns of mental retardation and the mentally retarded. The Division has given high priority to the activities which would demonstrate new and improved ways of providing services to the mentally retarded. Among these are such programs as those involving establishment of more effective methods of referral and consultation, improved methods of care, treatment, and rehabilitation, including services needed to maintain a continuum of care. In addition, programs have been made available for special training in the medical and behavioral sciences, either in basic or clinical sciences, and for training professional and non-professional personnel for both health care and social and rehabilitation services to the mentally retarded.

Family physicians and pediatricians are of prime importance in any scheme of providing adequate health services and constitute the first line of defense in meeting and coping with the problem of mental retardation. It is to the GP or the pediatrician that the family first comes with the child that is "just not like other children," they look to you to tell them what to do. We are glad to participate and support programs of "continuing education" such as this one, and any other methods which enable us to develop together a more effective participation in the requisite partnership for service to the mentally retarded.

42 Broadway

Shall We Scrap That Word "Sample"

It has been suggested by the *American Professional Pharmacist* (a journal) and by several pharmaceutical manufacturers, that the word "sample" be avoided in referring to drug specimens sent to you gratis. The word "sample" has an almost pejorative implication. The suggestion is that we call them "starter doses." What do you think? A letter to your editor here will be welcome. Write to P.O. Box 904, Trenton 08608.

Milk tablets are now available for ulcer patients with the advantages of portability and palatability.

Dispensing Milk In Tablet Form

Henry J. Konzelmann, M.D./Hillside

Milk is still the basic antacid food in the treatment of peptic ucler. Most other antacids are compared to this, as the standard essential food, for their antacid quality. Gastroenterologists agree that three ounces of warm milk every three hours are desirable for the effective treatment of this disease. The one drawback of whole milk (particularly in the geriatric patient) is the cream. The cholesterol in cream plus the geriatric patient's common difficulty digesting fats makes this a serious limitation High protein powdered milk is superior to whole milk. Here, the trouble is that the taste of powdered milk is not palatable to many; and further, it may be unavailable away from home.

Tablets made of high protein powdered milk are non-fat and very palatable. For these two reasons alone, this method of prescribing milk would seem to be the ideal way of administrating this beneficial requirement to control gastric acidity.

One P.M.T. (Pure Milk Tablet) is equivalent to an ounce of milk. One every hour keeps the acidity of the stomach close to a normal level with little variation. It relieves the symptoms of hyperacidity and supplies nourishment at the same time.

The six advantages of P.M.T. compared to whole milk or antacid medication are:

1. It need not be refrigerated.

2. It need not be warmed before taken.

3. It can be carried about the person loosely or in handy packages.

4. It can be taken without embarrassment during times of stress, even at important meetings or social events.

5. There is no limit to the amount that can be taken safely. P.M.T. is well tolerated unless allergy to milk exists.

6. P.M.T. will not cause black stool or black tongue.

P.M.T. is a useful product suitable for every one regardless of age or condition. In children P.M.T. contains milk protein for growth and development and in adults it supplies an alkali food with little cholesterol.

Many executives, particularly those under stress, develop an increase in gastric acidity. P.M.T. controls this acidity and thus hopefully will minimize a true ulcer in an individual trapped in pre-ulcer situations. Executives may well be the beneficiary for P.M.T.'s most beneficial effect.

65 King Street

In commenting on the above article, Dr. Ferdinand G. Weissbrod, an East Orange gastroenterologist, writes:

There is no question that milk represents the mainstay in ulcer management, and that frequent feeding of milk without antacids is efficient in relieving symptoms of ulcer.

The advantages mentioned for this product are no different than for the common aluminum magnesium preparations, with the exception of the nutritive value of milk.

The only disadvantage of the tablet would be in patients who cannot tolerate milk because of a lactase enzyme deficiency in the gastrointestinal tract. Other factors such as disintegration of the preparation, rapidity of action, and duration of neutralization were not mentioned in this paper.

The basic proposition is correct and the overall neutralizing efficiency of the tablet compares favorably with the aluminum magnesium tablets; as a matter of fact some of these latter preparations are mixed with skimmed milk powder.

Modern peripheral vascular surgery offers new hope to previously hopeless arterial disease of the lower extremities.

Arteriosclerotic Lesions Affecting The Lower Extremity*

Diagnosis and Operative Treatment

Howard C. Baron, M.D./New York

Due to the extension of life expectancy, we are faced with increasing numbers of patients with symptomatic arteriosclerotic lesions involving the lower extremities. Within the last few years, the operative management of occlusive arterial disease has improved considerably. Surgical treatment of arteriosclerosis, especially of the trunk arteries, has been particularly rewarding[1]. Careful evaluation of the results of surgery has also led to agreement among surgeons in selecting optimal methods of revascularization for peripheral arterial disease.

Angiography has made possible a precise evaluation of the extent of the occlusive arterial disease. These studies make it possible to determine the status of the arterial tree and to localize the level and extent of the intra-arterial block. In addition, the arterial "run-in" and "run-off" may also be evaluated. The great improvement in results from vascular surgery can be attributed to the availability of contrast media of high density and relative safety, improved roentgenographic technics, and a decade of experience with selected operative revascularization procedures.

As early as 1924, sodium iodide was used successfully for roentgenographic visualization of peripheral arteries[2]. The feasibility of abdominal aortography[3] as a satisfactory diagnostic procedure was demonstrated using this compound in 1929. Although a 50 per cent solution of diatrizoate sodium (Hypaque®) is most frequently used for angiography and is quite satisfactory, we prefer a 75 per cent solution of the mixed sodium and methylglucamine salts of diatrizoate (Hypaque-M®) for greater contrast in translumbar aortography. We routinely use the 50 per cent solution of diatrizoate sodium for peripheral arteriography. To date we have observed no serious local or systemic reactions with the use of either medium and have found them to be the safest of the currently available materials for angiographic visualization of the arterial system. This has been borne out by the study of Killen, Lance, and Owens[4].

We use percutaneous translumbar aortography for the preliminary studies. The translumbar route has proved to be safe, and with experience, is more reliable than the retrograde femoral catheter method in which entry through diseased or stenosed arteries might be more hazardous, or indeed impractical, because of intra-luminal obstruction. We make the retrograde transfemoral approach using a pressure injector only in patients who require additional or selective angiographic procedures.

The degree of arterial luminal obstruction necessary to produce symptoms of arterial in-

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sufficiency varies with the site of the lesion and the anatomic location of the artery. Generally this insidious process allows a collateral circulation to develop around the block and is sufficient to prevent ischemic necrosis; however, if the collateral circulation is not sufficient to provide an adequate flow of arterial blood to the involved limb during periods of work—for instance in walking—"work ischemia" manifested by claudication results. When the atherosclerotic areas are multiple and involve more than one artery in an extremity (or when the occlusion spreads thus reducing the number of collaterals to an area), ischemia may become severe enough to precipitate gangrene of the involved limb.

Surgical Indications

In the selection of patients to be considered for direct arterial surgery due to atherosclerotic lesions, one may usually establish two categories: (1) the patient in the fourth, fifth or sixth decade with disabling claudication of one limb, but who is otherwise in general good health, and (2) the patient in the sixth to seventh decade suffering from rest pain occasioned by severe limb ischemia and impending loss of limb.

In becoming more familiar with the disease one must readjust his conception of the age commonly associated with the onset of atherosclerosis and recognize that this disease is not uncommon in younger people. Previous reports have shown an average age of 50 in patients whose major disease process is localized in the arterial tree above the inguinal ligament. But it is not unusual to find patients in their late thirties and forties who have symptoms resulting from diminished arterial flow to an extremity dating back for several years.

Patients were recommended for reconstructive arterial operations of the aorto-iliac arterial system who had symptomatic arteriosclerotic occlusive disease. The three major indications were: (1) severe or disabling intermittent claudication, (2) patients exhibiting impending or incipient ischemia of a limb manifested by rest pain and skin changes associated with a complaint of cold or a numb feeling in the extremity or in one of the digits, and (3) patients exhibiting frank gangrene of a digit or the heel.

The patient with intermittent claudication as the only symptom (and in whom the claudication is not so disabling as to impair that function) should be treated conservatively with a potent vasoactive peripheral vasodilator, vascular exercise and instruction in meticulous foot hygiene. However, if the patient is unable to maintain a functional existence or if his social activities are unreasonably curtailed as a result of intermittent claudication, then elective arterial reconstructive surgery is indicated. Patients with "rest pain," the presence of pre-gangrenous areas of the lower extremity or frank gangrene of a toe or heel are candidates for immediate vascular surgery.

Patients with advanced arterial occlusive lesions of the aortoilio-femoral arterial system in whom amputation is contemplated should have an arteriogram of the involved extremity prior to amputation in the hope of avoiding such a disabling procedure. Even though the distal "run-off of the arterial circulation is deficient, the limb salvage rate is sufficiently high to warrant an aggressive approach to the leg threatened with amputation.

Operative Correction

Atherosclerotic occlusive disease involving the aorto-iliac and femoral arteries is frequently segmental in nature and may be successfully corrected by a variety of operative technics. The major operative categories are thromboendarterectomy and angioplasty; excision of the occluded arterial segment and graft replacement; bypass grafting of the occluded artery, and lumbar sympathectomy. Various combinations of these operative methods may be tried in overcoming the basic problem of segmental or extensive atherosclerotic disease of the extremities.

Thromboendarterectomy

Since the introduction of thromboendarterectomy by dos Santos,[5] many surgeons have recorded their experiences with this opera-

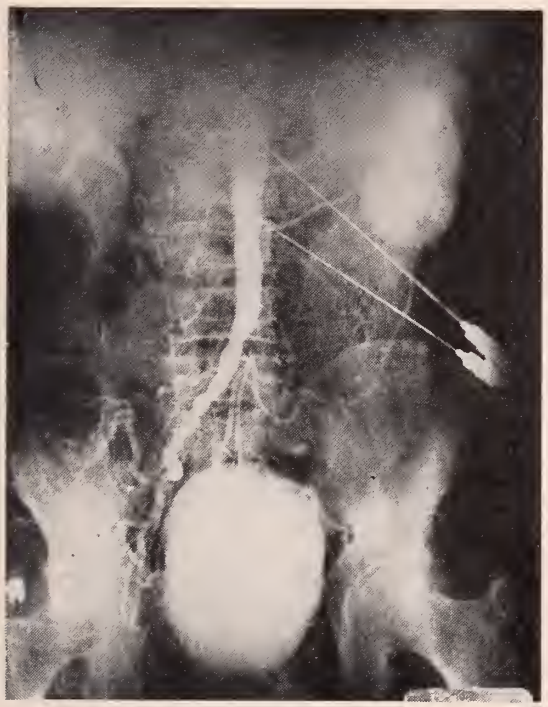


Figure 1

Preoperative percutaneous translumbar aortogram of a 56-year-old man illustrating extensive aorto-iliac occlusive disease.

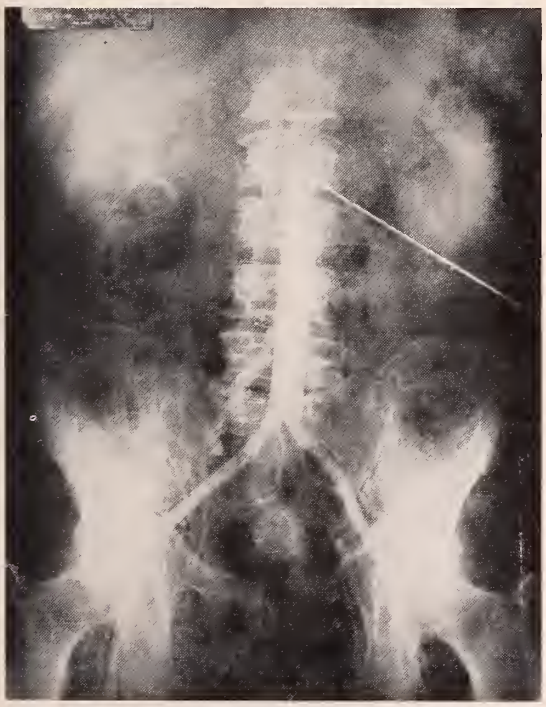


Figure 2

Postoperative aortogram shows the bifurcation prosthesis functioning in satisfactory manner. The proximal portion of the graft was anastomized to the abdominal aorta below the origin of the renal arteries. The distal anastomoses were attached to the common femoral arteries at the origin of the profunda artery.



Figure 3

Percutaneous translumbar aortogram illustrating an aneurysm of the distal aorta associated with atherosclerotic disease of the iliac arteries.



Figure 4

Aortogram made postoperatively illustrating excision and graft replacement for an arteriosclerotic aneurysm lesion of the distal aorta.

tion. The rationale is the re-establishment of arterial flow by disobstruction of the arterial lumen[6]. Thromboendarterectomy is physiologically sound. Excellent results may be anticipated when this is done for correcting segmental vascular disease of the major arteries. Some[7] have used this procedure for treating extensive lesions of the aortoilio-femoral vessels. However, we prefer to limit thromboendarterectomy to segmental lesions and to use an autogenous vein patch to close the arteriotomy. More recently we have tried "gas endarterectomy" with favorable results. This method of removal of luminal obstruction nas been reported by Sobel *et al*[8].

Use of a patch for closing the arteriotomy incision after thromboendarterectomy contributes to the success of the operation. The patch can be either a synthetic fabric such as Dacron® or, preferably, an autogenous vein patch. The patch is put into the arteriotomy defect. It helps maintain an adequate caliber at the operative site[9] and also permits adequate outflow[10] which is an important factor in preventing postoperative thrombosis.

Autogenous veins can successfully be inserted into medium-caliber arteries without the risk of aneurysmal dilatation. A vein patch is biologically more suitable than synthetic fabric, although on occasion venous material may be clinically unobtainable because of previous stripping of the saphenous vein.

Another important factor in preventing postoperative thrombosis at the endarterectomy site is maintenance of high flow rate. This flow rate is predicated on the presence of a good proximal flow of blood (run-in) and a patent distal (run-off) arterial tree. Patients who have in the immediate postoperative period required re-operation for thrombotic reocclusion often have inadequate run-off. The inadequate run-off may be the result of the surgeon's failure to carry the thromboendarterectomy far enough distal to the original occlusion. Two other factors contributing to the formation of a postoperative thrombotic occlusion are dissection of the atheroma at the distal extent of the thromboendarterectomy, and (perhaps most important) prolonged arterial occlusion time.

Excision and Graft Replacement

Extensive disease of the terminal abdominal aorta and proximal iliac arteries may be dealt with by resection of the diseased distal segment and replacement with a synthetic Dacron® graft. This procedure is best done in the presence of aneurysmal disease. The distal anastomosis is accomplished by joining the end of the graft to the common iliac arteries. The graft may either be attached to the external iliac arteries or brought into the thigh and joined to the common femoral arteries.

Bypass Graft

Bypass grafting with a Dacron® prosthetic is often done in extensive disease that involves the lower aorta and iliac arteries. Rather than dealing directly with the vascular problem, this procedure bypasses the lesion. In this manner, extensive disease of terminal aortic vessels can be handled with minimal operative trauma. The anastomoses generally are done end-to-side to the abdominal aorta, below the origin of the renal arteries. The distal anastomoses may be attached to the iliac arteries or brought out in the thigh and attached to the femoral arteries, depending upon the distal limits of the atherosclerotic process. During the performance of a bypass, the surgeon may find that localized thromboendarterectomy at the site of graft insertion is of great help in improving flow to the affected limb, especially if the site of insertion is at the level of the bifurcation of the superficial and profunda femoral vessels.

It has been our experience that (even in the presence of severe occlusive disease of the major extremity arteries) bypass grafting from the abdominal aorta to the level of the *profunda femoris* artery can be of great benefit to the patient. The *profunda femoris* arterial circulation is not as frequently involved in the atherosclerotic process as is the superficial femoral arterial circulation. By bringing in an adequate flow of blood to the ischemic extremity by means of this circulation, the vi-

ability of the limb may be maintained and, in many instances, complete amelioration of symptoms may result.

Sympathectomy

Historically[11], the first surgical procedure tried for aortoiliac obstruction was bilateral lumbar sympathectomy with or without concomitant resection of the occluded aortic bifurcation. Lumbar sympathectomy was considered outmoded and was discarded a decade ago with the availability of direct arterial surgery for revascularization. Today, however, lumbar sympathectomy is once again regarded as an effective measure. The operation is used increasingly in conjunction with arterial revascularization procedures. In addition, sympathectomy is of benefit in advanced peripheral arterial occlusive diseases. In this manner, lumbar sympathectomy should be considered complementary, not competitive with direct arterial surgical technics.

Peripheral arterial occlusive disease is a manifestation of an underlying pathological process which may simultaneously attack the peripheral, renal, coronary, and cerebral arterial systems. This progression of the basic disease, while disconcerting, is to be expected. Atherosclerotic occlusive disease involving the aortoiliac and femoral arteries is frequently segmental and may be corrected by a variety of operative methods.

Surgery, supported by medical management with a direct-acting vasodilating drug to help reduce peripheral resistance and to maintain distal run-off channels, results not only in the salvage of the ischemic extremity, but may restore it to a functional symptom free status allowing for the resumption of the patient's normal activities.

Conclusion

The immediate results with the above-described procedures have been excellent. Follow-up studies indicate continuing satisfactory results in the major artery reconstructions. The rehabilitation to useful, symptom-free existence of a large number of patients who would otherwise be disabled by arterial disease is the most worthwhile goal of reconstructive surgery. The excellent salvage rate of the ischemic limb and the gratifying relief of symptoms achieved in this group of patients are significant factors in assessing the important role of vascular surgery in the management of atherosclerotic vascular disease.

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Jewish Memorial Hospital

1968 Annual Meeting

Saturday, Sunday, Monday, Tuesday, Wednesday May 18-22, 1968

Haddon Hall, Atlantic City

This is one of the most vivid and eloquent descriptions ever published on the emotional impact of cardiac surgery on one of its patients.

Psychiatric Complications Of Cardiac Surgery*

Allen Welkind, M.D./Maplewood

Modern surgery has brought monumental changes in the treatment of congenital and acquired heart disease. Prior to entering psychiatry, I had some years of experience as a cardiorespiratory physiologist on thoracic and cardiac surgical services. For some time I continued in these fields concomitantly with my beginning years in psychiatry, allowing me the opportunity to observe the psychological reactions to cardiac surgery. During the early days of cardiac surgery, anxiety was observed preoperatively in all cases and mild depression was common. In one case, a chronic schizophrenic reaction was precipitated postoperatively. This was before the era of open cardiac surgery, with the oxygenating bypass. However, even then it was clear that there were preoperative and postoperative psychiatric complications. In the early 50's those patients with rheumatic or congenital heart disease, who were advised to go to surgery, knew that they were being exposed to a new field of surgery. They knew that the surgeons had little previous experience, and that mortality was high. The anticipation of dying on the operating table made for a high incidence of intense preoperative anxiety. Many patients preferred to wait for death, no matter how much dyspnea, cyanosis, and hemoptysis they had experienced. Patients were often pressured by their families to go to surgery. Young children with congenital heart disorders were without real awareness of the danger. I wonder now how much the ambivalence of the parents of these children with congenital heart disease aided pioneers in this field in increasing their skills.

The adults who were brave enough knew that they had no hope of longer life without surgery. Some were so unhappy in their limited, chronically sick lives, that they welcomed death, rather than live on. Perhaps some were using the surgery as a suicidal effort, with the surgeon or anesthetist as the instrument.

However, others survived and, happily, in ever increasing numbers. We then began to encounter more frequent postoperative psychiatric complications. Studies had been reported on the emotional problems of patients with chronic heart disease.[1,2] There had been papers on the psychiatric reactions to general surgery,[3,4] including tonsillectomy in children.[5] We had some understanding of these reactions. It was some time before depression and other psychiatric disorders were noted following cardiac surgery. Not until 1954, did a large enough series of mitral commissurotomies lead to the publishing of a definitive study.[6] Fox, Rizzo, and Gifford[6] commented: "The various psychologic responses of these patients to hospitilization and operation illustrated the effects of prolonged adaptation to an increasingly disabling disease which is followed by surgical rescue but also the chance of sudden death." All were victims of rheumatic heart disease with years of illness before coming to surgery. They had experienced heart failure and the concomitant narrowing of their lives with the vital decisions concerning marriage, pregnancy, choice

* Presented November 15, 1967 at the meeting of the Essex chapter of the New Jersey Neuropsychiatric Association. Dr. Welkind is Assistant Clinical Professor of Psychiatry at the New Jersey College of Medicine, from which this work comes.

of vocation, and intimate details of daily living.

Each patient had to make serious adjustments, the reaction to which was characterized by the demands of reality and by the nature of his psychological defenses. His sense of danger was realistically determined but so were phantasies about his illness. What might happen on the table also influenced his feelings and his behavior. Having made a long term adaptation to progressive limitation of activities, he now had to make emergency defenses for his hospital situation both before and after operation.

Consider the importance of the heart as the organ of life. Our language is full of the emotional connection; we are heart-sick, heavy-hearted, down-hearted, hard-hearted light-hearted, and so on. The child who recognizes that his activity is limited by his parents and doctor may not recognize its full meaning until later. He is simply irritated by the limitation. Only when he becomes short of breath or edematous does he understand. He may know that he has heart disease for years before then but he denies it. Some women, after a first pregnancy produces failure, ignore it and go on to further pregnancies, each time with failure. Denial plays a major role here. Others defy the illness by going on with strenuous athletics until they have hemoptysis. Some restrict themselves by living the "clean life" — they become rigidly moral. Restriction of physical effort also coincides with their aggressive and competitive urges. They become good, obedient, and passive. Others become defiant and rebellious. Many develop depression when they recognize the real situation and know that surgery may be in the cards. Here is a typical case of such depression:

A 38 year-old married salesman was seen preoperatively because he was greatly disturbed by the fear of surgery. He had had rheumatic fever in his early teens but got along well after the illness. He was not limited in any noticeable way although he had been told of the rheumatic fever and the valvular damage. He reacted to this by denial and defiance. "I feel great. I can do anything everyone else can." He actively engaged in athletics such as tennis and golf, becoming proficient at both. Four years before I saw him, he had developed bacterial endocarditis following root canal surgery on an infected tooth. This reacted well to penicillin but then his cardiac status worsened. He was found to have aortic and mitral stenosis and mild insufficiency. His physical capacity was markedly reduced by increasing shortness of breath, cough, ankle edema, and hemopstysis during the next three years. He was no longer the denying, belligerent athlete. Now he sought assurance and encouragement. He was overtly afraid that he would not live through the operation. Psychotherapy helped him master the anxiety; through this, the ego strength he had lost returned. He knew that he would die untreated and was willing to take the chance that surgery offered.

Preoperatively he was realistic about the future. Having been a successful business man and athlete, he looked forward to the future hopefully. Surgery was uneventful. A Starr-Edwards valve replaced the aortic valve, and finger fracture of the mitral made a wider aperture. He fibrillated postopertatively and had to be electrically converted to normal sinus rhythm. He did not develop postoperative delirium. He made a very good recovery and went home a month later. Then he developed a rather serious depression. "All that pain, and now I'm going to die anyway!" He was given Tofranil® and Mellaril® and was seen in psychotherapy frequently, first at home and then in the office. He told me that many patients had died when he was in the hospital. The defibrillation was as serious a threat to him as the surgery. It amazed him that he could return from the second procedure alive, and he wondered why he recovered and others died. There was considerable guilt which was not explored. His depression lifted, he was "heartened" that his cardiac status had begun to improve. He seems, some eighteen months later, fully recovered emotionally and now regards his problem realistically.

Kennedy and Bakst[7] followed a large series of patients through the following eight steps: (1) Admission, (2) Diagnostic Evaluation. *which is full of new and frightening experiences,* (3) Awaiting the Verdict, (4) Awaiting the Surgery, (5) Surgery, (6) Recovery Room, (7) Convalescence, and (8) Discharge to Normal Life. Each step had its own variety and degree of anxiety, all based on the ultimate threat, the prospect of immediate death. The authors studied the manner in which the patients dealt with this in terms of defensive behavior.

Their years of illness before the contemplated surgery had produced long term and short term (or emergency) defenses. Some were normal, and realistic; too often, they were neurotic. The emergency or short term defense patterns, such as flight vs. fight, fear vs. rage, the role of pain and pleasure principle, regression, denial mechanisms, repetition-compulsion, and of course, the death wish. Since man cannot easily contemplate the possibility of his own non-existence he desperately tries to cover it over and develops all kinds

of free floating anxiety, expressed by dreams, associations, and slips; his confict is between the will to live and the will to die.

Even healthy ego defenses are taxed to the utmost. From my own experience it is clear that healthy denial is the major mechanism. These patients recognize the risks and the possibility of death. They deny the fear of anesthesia, periods of helplessness and unconsciousness, the difficulties in the operating room, postoperative distress, and the recovery room. Psychiatric help is a *must* preoperatively for *all* patients. This is needed to overcome the threat that the temporary dependency of surgery produces, and to arrive at realistic independence. Those who are unprepared may have difficulty at the postoperative period.

In general, good preoperative psychiatric care will reveal the fears and major defenses. Some patients don't want rescue, are addicted to illness, and don't do well in surgery. They fear the freedom health gives them. Those who were not carefully studied by psychiatrists in the early years were either ambivalent or panicked and often died after surgery. Now, when recognized, these patients are referred to longer psychotherapy and eventually are reconsidered for surgery.

The patient who recovers finds that his new health requires him to reorganize his entire life. His previous life is distorted and his early concepts inaccurate. He sees himself as disabled and with a short life span. All this is changed. He must be helped to face the challenge.

A description of the surgical procedure perhaps will give a clearer picture of the physical stress the patient undergoes, and how it adds to the heavy burden of anxiety. Intravenous pentobarbital is followed by intratracheal inhalation anesthesia. Hypothermia is begun. The lower abdomen is entered retroperitoneally to introduce the cardiopulmonary bypass. The thorax is opened and the heart exposed. The ascending aorta is then clamped. This is done by a team before the heart surgery is begun. All the monitors have been established, such as electrocardiograph, electrolytes, intracardiac catheters, both right and left side, and urethral catheter. Then the heart is stopped, the valves repaired or replaced, and the entire procedure is slowly reversed. The elapsed time varies from six to ten hours, although it may take as long as twelve when two or three valves are replaced.

The patient is then transferred to an intensive care unit. He wakes at the moment he is being put to bed. There is minimal sedation to avoid atelectasis, so the pain is severe. The patient is totally helpless. He is connected with intravenous solutions and to the same electrodes and cardiac catheters introduced for surgery. Nurses are in constant attendance turning the patient from side to side at twenty minute intervals, urging deep breathing and coughing efforts; he is spoon fed sips of water, being given injections of antibiotics, and some medications are introduced rectally. Blood pressures, radial and apical pulse rate, and rectal temperatures are frequently taken. This life-saving plethora of nursing care plays a large role in the production of emotional reactions. Helplessness is a serious ego injury, causing anxiety of high intensity. We know that minor illnesses that require bedrest often cause regression. Cardiac surgery makes the patient a helpless infant who can do nothing but cry for relief of pain and distress.

Patients rarely stay in the intensive care unit for less than 48 hours, and often stay four to five days. During this time they do nothing for themselves. The sensory system is deluged, much like the torture that United Nations prisoners were subjected to in Korea. It is monotonous. The patient is too busy being treated to get restful sleep.

During the first two days postoperatively, the psychological difficulties are realistically expressed in terms of pain. The average well-motivated patient is delighted to have survived, and in the main, he regards every hour and day postoperatively as an indication that he is on his way to home and recovery. This may not be, for some patients, what they consciously or unconsciously want. Varying degrees of depression are noted in the first few days. When the patient is moved to the inter-

mediate unit the routine becomes dull. There is a let down, and the regressed patient may feel he is neglected.

At this time, usually about the third or fourth postoperative day, a more impressive disorder appears rather commonly. This may be organic, or psychological, or a combination or both. It expresses itself in a delirious state. There is impaired consciousness, motor restlessness, disordered thinking, sensory disturbances, visual hallucinations or illusions, auditory hallucinations, and disorientation. It usually follows a lucid interval, occasionally after one or two days but commonly on the fourth day. It may last only a day or two, but more often it is of four to five days duration. Some observers have seen it stop when the patient is transferred into the intermediate unit. It often stops after a night of restful sleep. The incidence varies from 22 to 78 per cent. Kornfeld[8] says that the longer the operation, and the more time on the bypass, (this sometimes lasts two to three hours in triple valve replacements) the higher the incidence of the delirium. It is less common in closed heart surgery and is rare in children.

This delirium has several possible components. The effects of the surgery itself have to be considered: (1) Toxic absorption from the trauma, (2) Hemolysis during the bypass, (3) Sodium, Potassium, and Magnesium imbalance (although this is carefully controlled at all times), (4) Reaction to sedation and barbituates, (5) Dehydration, (6) Alcoholics who react postoperatively (but this is rare), (7) Brain damage before or during surgery such as cerebral anoxia, embolism, or thrombosis, or during profound hypothermia. Embolism is not uncommon following mitral repairs.

Sleep deprivation would seem to be a likely cause, as does the sensory motor problem. Both can cause hallucinations and disordered thinking. The monotony and the lack of meaningful stimulation would also contribute. Auditory hallucinations have been described in normal people exposed to strong rhythmic backgrounds. There are often musical hallucinations. The clicking of the ECG monitor may induce this. As far as we know there are no permanent sequelae following the delirium.

There are other psychiatric reactions to cardiac surgery. These include disabling anxiety states, conversion reactions, an occasional paranoid reaction, and hypomanic state. An occasional depression is of psychotic intensity. I have already mentioned the schizophrenic reactions. The preoperative anxiety and the surgical stress obviously will precipitate an already predisposed patient.

Careful screening of all patients is essential to prevent not only psychological morbidity but also complications that can produce such physiologic disorders as severe and even fatal arrhythmias and pre- and postoperative pulmonary edema. Anxiety and its fatal effects have been mentioned by several authors.[8,9,10] Not uncommonly, patients tell of their expectation of death even when the preoperative prognosis is good, but such patients sometimes die even under ideal surgical circumstances. Blachly and Starr[9] in their series, described eleven deaths in 35 cases during operation or in the first week postoperatively. Three patients were paranoids, who died during surgery: and eight were seriously depressed preoperatively. These authors list many causes of delirium, including inadequate cerebral perfusion, changes in the serum protein caused by the bypass and microemboli plugging the cerebral capillaries. Inadequate cerebral circulation may cause changes such as seen in carbon monoxide poisoning, with a lag between trauma and symptom formation.

Cerebral embolic reactions[11] have sometimes caused behavioral changes easily mistaken for delirium or other psychoses. Frank gnostic changes accompanied by paralyses do occur because of atrial thrombi, valvular or vascular calcific fragments, air emboli, or hematological aggregates of "white" blood cells and platelets. Microemboli may come loose from the surface of the prothesis (which is covered by fibrinous beginnings of a form of endothelium) and lodge in cerebral and other capillaries. No noticeable paralysis may be seen but gnostic reactions could result which can be mistaken as psychosis or delirium. I have seen two such cases. The first was in a

physician who had a Starr-Edwards prosthesis replacing a valve badly damaged by subacute bacterial endocarditis. He recovered uneventfully except for a bout of atrial fibrillation on the 6th and 7th day, which returned to regular sinus rhythm under digitalis and quinidine. Coumadin was discontinued after discharge three weeks postoperatively. He returned to work after three months. Two months later he became faint. His speech became incoherent. His physician saw him almost at once, and found a mild aphasia and apraxia. The following day further tests showed alexia and agraphia. There were subungual "splinters." The gnostic difficulties disappeared in two weeks but he continued to have trouble occasionally in misusing, mispronouncing, and having difficulty in the choice of words, or remembering the exact word he wanted. He was put back on coumadin and for two years encountered no further trouble. At that time, for no apparent reason his prothrombin time was excessively prolonged. Coumadin was discontinued for two days. On the third day he again had an attack of fainting, with aphasia, alexia, agraphia and apraxia. Recovery was quicker. Brandenberg[12] describes a "rebound phenomenon" when coumadin is discontinued sharply. There is a sudden increase in microemboli. He advises that there should be a reduction, but not a discontinuation of the coumadin.

I saw another patient in whom coumadin played a role in gnostic difficulties. On the tenth day following a mitral valve replacement with a Starr-Edwards prosthesis, prothrombin time was excessively prolonged. The drug was stopped, to allow for adjustment. She had had no delirium or complications but on the twelfth day the patient became incoherent and her anxiety was intense. The attending surgeons labelled this as a "psychotic episode." Examination of the nail bed showed splinter thrombi. She had aphasia, alexia, and agraphia. When this was explained to her, her anxiety quickly subsided. She recovered in the same manner as the first case.

Another unusual disorder (this one a purely psychological one) was described earlier.[14] An 18 year-old boy had mitral and aortic insufficiency and stenosis. He was operated on with the intention of replacing both valves. After the mitral valve was replaced his condition deteriorated. He was closed with the hope of replacing the aortic valve at a later date. He was irritable and hostile to the staff, postoperatively. He denied any anxiety before or after surgery. He was angry that the surgery was not completed. He then began to notice the clicking noise of the valve all day. He was frightened that the heart would stop and his hyperacute awareness of the "click" served to remind him that his heart was still functioning. Patients with paroxysmal tachycardia often give a similar story. And, although I have had no personal experience with this, I would expect a similar kind of morbid "listening" from patients who have had cardiac arrests and were resuscitated.

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638 Prospect Street

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

January 21, 1968

A regular meeting of the Board of Trustees was held on January 21, 1968, at the Executive Offices. For your further information, detailed minutes are on file with the Secretary of your county society. A summary of the significant actions follows:

Nicholas F. Alfano, M.D. . . . Adopted the following memorial resolution and authorized a contribution, in the amount of $50, to the Medical Student Loan Fund in memory of Dr. Alfano:

NICHOLAS FRANCIS ALFANO, M.D.
1910 — 1968

Whereas, God in His wisdom has seen fit to summon Nicholas Francis Alfano, M.D., from our midst; and

Whereas, through diligent and loyal services to the Medical-Surgical Plan, culminating in his leadership as its president, Dr. Alfano consistently and equally advanced the interests of both the public and the members of The Medical Society of New Jersey; and

Whereas, by the integrity of his character, his devotion to humanitarian goals, and his endearing personal traits he was a source of encouragement and inspiration to all who knew him; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey records profound grief at his untimely passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting, and another copy, suitably prepared, be presented to his bereaved family.

Blood Bank Credits Under Blue Cross . . . Directed that the Essex County Medical Society and the Essex County Blood Bank be informed that the Board of Blue Cross is currently conducting a survey relating to costs in the implementation of MSNJ's resolution (#19, adopted by the 1967 House of Delegates) concerning blood bank credits under Blue Cross.

AMA Councils and Committees . . . Noted that the AMA Board of Trustees had reappointed the following to councils and committees from New Jersey:

David B. Allman, M.D., Brigantine
Council on Legislative Activities

R. E. Eckardt, M.D., Linden
Committee on Occupational Toxicology

Henry H. Kessler, M.D., Newark
Committee on Rating of Mental and Physical Impairment

AMA Congress on Medical Education . . . Authorized the attendance (with expenses paid) of a representative of the Society's Committee on Medical Education at the Congress on Medical Education, to be held February 11th and 12th in Chicago.

AMA Workshop on Medicine and Religion . . . Authorized the attendance (with expenses paid) of the Chairman of MSNJ's Committee on Medicine and Religion, Dr. Jerome G. Kaufman, at the AMA Workshop on Medicine and Religion, to be held at the Sheraton-Tenny, La Guardia Airport, New York, on March 23rd.

AMA Congress on Socio-Economics of Health Care . . . Authorized the attendance (with expenses paid) of Dr. Nicholas E. Marchione at the Congress on Socio-Economics of Health Care, to be held March 22nd and 23rd in Chicago.

Annual Meeting General Session . . . Agreed that the general session for the 1968 annual meeting be the inauguration ceremonies of the incoming President, at which policies of medicine will be discussed.

. . . Agreed that the AMA President should be invited to this general session to make his presentation to the Society.

Medical-Surgical Plan Open Discussion . . . Agreed that an open discussion on the Medical-Surgical Plan immediately follow the first session of the House of Delegates on May 18, 1968.

Liability Insurance Coverage . . . Approved the following recommendations of the Committee on Medical Defense and Insurance, in

reference to the notification by American Mutual Liability Insurance Company of the cancellation (as of November 1, 1968) of the agreement between American Mutual and MSNJ, and retirement from the entire risk; also that no new business would be accepted after January 15, 1968:

1. That, subject to approval of Legal Counsel, the Chairman of the Committee on Medical Defense and Insurance, Chairman of the Committee to Investigate Other Insurance Companies, and the Executive Director, the Board of Trustees send a letter to the American Mutual Liability Insurance Company, in which the following elements are incorporated:

(a) Acknowledgement of American Mutual's letter of January 8, 1968, indicating the Company's decision to terminate coverage.

(b) Expression of regret that the company's Vice-President has chosen erroneously to interpret the Society's purpose in conducting the current survey.

(c) Citation of the relevant section of the Society's By-laws, which indicate that, in conducting the survey, the Committee is merely carrying out its assigned responsibility to make available "optimum protection of all members."

(d) Indication that the survey — it was generally expected — would demonstrate that "optimum protection" *was* being afforded by American Mutual. Such investigations, therefore, do not imply loss of confidence in American Mutual.

(e) That the minutes of the Committee's November 12, 1967 meeting reflect that the decision to conduct the survey was made "without prejudice to the Society's present carrier."

(f) Request that American Mutual rescind its decision not to accept new business after January 15, 1968.

(g) Indication that MSNJ will continue to serve the Loss Control Program until its relationship with American Mutual is formally and finally terminated.

(h) Expression of surprise and concern at the peremptory tone of the vice-president's letter and the precipitate decisions which it contains.

(i) Intimation that the Society is open to further discussion of the entire matter with representatives of the Company.

2. That, over the signature of Dr. Marcus H. Greifinger (as chairman of the subcommittee) and with his cooperation, letters of initial inquiry be sent to Liberty Mutual Insurance Company, Travelers Insurance Company, Aetna Insurance Company, and Nationwide Insurance Company, and arrangements be made for the appearance of representatives before the Committee.

. . . Directed that applicants for new coverage be alerted to the situation with American Mutual and advised to consult brokers of their choice. Without specific recommendation, new members may be informed that the following carriers (listed alphabetically) have been reported as willing to make coverage available: Aetna, Employers Insurance of Wausau, General Accident, Hartford, Liberty Mutual, Maryland Casualty, North American, and Travelers.

Council on Public Health . . . Approved the following recommendations from the Council on Public Health:

1. Air Pollution:

That the Commissioner of Health be asked to authorize reprinting in the MSNJ *Journal* of his article on air and water pollution, which appeared in the May 1967 issue of *Public Health News.*

2. Conservation of Vision:

That MSNJ sponsor the annual Eye Health Screening Program in 1968, with such modifications as the Committee might recommend and the Council on Public Health and the Board of Trustees subsequently approve.

3. Maternal and Infant Welfare:

a. That MSNJ's "Standards For An Obstetrical Department" be revised by the addition of certain amendments.

b. That MSNJ obtain from the Department of Health information relative to the legality of field physicians' securing copies of pertinent medical records from hospitals in cases of maternal death.

c. That the Chief Medical Examiner of the State of New Jersey and the chairmen of the departments of obstetrics of the State's medical schools be named consultants to the Special Committee on Maternal and Infant Welfare.

4. Viral Hepatitis:

William J. Dougherty, M.D., Director of the Division of Preventable Diseases of the New Jersey State Department of Health, called attention to the increasing problem of viral hepatitis among drug users, especially in the age group from 15 to 24. He alerted MSNJ and all physicians to the problem and its association with young drug users (as indicated) — chiefly males. Dr. Dougherty urged that (1) full reporting of such cases be encouraged; (2) the medical profession exercise positive leadership in this area of concern; and (3) efforts be made to establish a confidential, medically-oriented reporting system to the Department of Institutions and Agencies, on a form to be evolved by the Department.

Recommendations:

(a) That the entire matter be referred for study and action to the Special Committee on Drug Addiction of the Council on Mental Health.

(b) That Dr. Dougherty be invited to prepare an article for submission to *The Journal,* to inform members of the existence and scope of the problem and its related aspects.

Constitution and By-Laws . . . The Committee on Revision of Constitution and By-Laws noted that the proposed revision to the Constitution, which was approved by the 1967 House, will be presented to the 1968 House of Delegates in May for final action. In this connection, the Committee reviewed relevant sections of the Bylaws which might be affected by the constitutional change.

Chapter VI, Section 5(a) of the Bylaws sets the quorum of the Board at nine — or half the total members of the Board at the present time. This same section of the Bylaws sets at four the number of Trustees who may petition for special meetings.

As the membership of the Society stands at December 31, 1967, final adoption of the constitutional amendment would increase membership on the Board to 20. As a result of this increase, the Committee discussed the necessity and/or desirability of amending this section of the Bylaws.

. . . Approved the following recommendation pertaining to the above:

That no change be made.

Resolutions From Essex County . . . Referred the following resolutions from the Essex County Medical Society to the 1968 House of Delegates:

1. *Hospital Chaplaincy Programs* . . . resolved, that MSNJ recommend to the New Jersey Hospital Association that each hospital in New Jersey support a chaplaincy program by providing space for it, and, wherever possible, financial support.

2. *Pilot Certification Examination* . . . resolved, that MSNJ favor revision of the FAA medical certification and recertification form.

Resolution From Bergen County . . . Referred the following resolution from the Bergen County Medical Society to the 1968 House of Delegates:

Joint Commission on Accreditation of Hospitals . . . resolved, that the Joint Commission on Accreditation of Hospitals include in its basic accreditation criteria a provision that at least one-third of the members of that hospital governing body concerned with the formulation of policies, rules, and regulations be physicians in active practice in the area.

Title XIX Program in New Jersey . . . Directed that the recommendations of the Board of Public Welfare of the New Jersey Department of Institutions and Agencies relating to a Title XIX Program in New Jersey be published in THE JOURNAL for the information of the membership.

New Site and Headquarters Building . . . Approved a recommendation of the Treasurer that $50,000 from the excess and general surplus be set aside to establish a new reserve account entitled "New Site and Headquarters Building."

Medical-Surgical Plan Presidency . . . Adopted the following resolution for presentation to the Board of Trustees of Medical-Surgical Plan:

Whereas, the Bylaws of the Medical-Surgical Plan of New Jersey require that "The President shall be a Doctor of Medicine and a member of The Medical Society of New Jersey;" and

Whereas, the regretted and untimely death of Nicholas F. Alfano, M.D., has created a vacancy in the presidency of the Plan which can be permitted to continue only with progressive disadvantage to the operations of the Plan and the interests of its subscribers; now therefore be it

RESOLVED, that the Board of Trustees of the Medical-Surgical Plan of New Jersey be urged to elect a new President without delay, and that the new President be a Doctor of Medicine and a member of The Medical Society of New Jersey, as the Bylaws stipulate.

Project Hope Fellowships . . . Approved the granting of MSNJ fellowships to the following two members in connection with their participation with the S.S. Hope:

Eugene Loeser, M.D. (Morris County) — fellowship to be given at the beginning of his tour of duty, scheduled for April 15.

Michael LaPorta, M.D. (Monmouth County) — fellowship to be given immediately, since tour of duty has already been completed.

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Medicaid For New Jersey?

New Jersey is one of the few states without a Title 19 program ("Medicaid"). Our State Board of Public Welfare has urged that such a program become operational in New Jersey not later than January 1, 1970, or as early as July 1, 1969, if administratively and fiscally feasible. They asked that appropriate enabling legislation be enacted during the first half of 1968 to afford sufficient "lead time" for planning and executing the details of the program.

Estimates of the non-Federal costs for the first year of this program will require State funds in an amount exceeding $100,000,000.

Here, in question and answer form, are the recommendations of the Board of Public Welfare, dated November 14, 1967, approved by the State Board of Control, December 20, 1967, and received and reviewed by the Board of Trustees of The Medical Society of New Jersey on January 22, 1968. They are offered to the membership for their consideration.

1. Should New Jersey take advantage of the Amendments to the Social Security Act of 1965 referred to as Title XIX or Medicaid?

The Board of Public Welfare answers: Yes.

2. Who should be the administering agency for a Medicaid program in New Jersey?

The State Department of Institutions and Agencies, through the Division of Public Welfare, should be designated as the State authority to administer the program.

3. How should the responsibility for financing the non-Federal portion be allocated?

The non-federal part of the cost should be financed by the state and none of the costs imposed on local units of government.

4. Should the program include coverage for indigent persons and families not eligible for the Federally matched categorical assistance programs, (that is, persons and families receiving General Assistance from municipal welfare departments)?

The board of public welfare recommends automatic full coverage to all persons legally eligible to receive public assistance from any municipal, county, or state welfare, health, or rehabilitation agency.

5. Should the program include needy persons and families in the population other than those included by the terms of the Federal Act, that is, any class of "medically indigent?"

The program should include "medically indigent" persons and families. These should be defined, by administrative regulation (rather than by express statutory limitation), substantially as follows: that individuals and families with income and resources in amounts greater than would permit them to qualify to receive aid under the public assistance programs should be regarded as "medically indigent" when in any three-month period, expenditures incurred by them for medical services shall have reduced their remaining income and resources to below the public assistance level of eligibility. The amount of medical assistance granted shall be the amount needed to restore income and resources to the public assistance level of eligibility.

6. Shall the scope of service for the "indigent" be limited to those services mandatorily required under the terms of the Federal Act, or include all or some of the additional services permitted by the Federal Act?

At its start, the program ought to provide coverage for all "indigent" persons with respect to appropriate elements (administratively determined by the board of control) of groups of services permitted by the federal act (excluding only private duty nursing), as follows:

1. Inpatient hospital services (which must be reimbursed to the hospitals on the basis of reasonable cost);

2. Outpatient hospital services;

3. Physicians' services (whether furnished in the office, the patient's home, a hospital, a nursing home, or elsewhere);

4. Skilled nursing home services for persons over 21;

6. Any remedial or medical care furnished by practitioners licensed in the State;

7. Home health services;

8. Clinic services;

9. Dental services;

10. Physical therapy and related services;

11. Prescribed drugs, dentures, prosthetic devices, and eyeglasses.

12. Other diagnostic, screening, preventive, and rehabilitative services; and

13. Hospital and nursing home services for individuals aged 65 and over in institutions for mental disease and tuberculosis.

7. Shall the scope of service for the "medically indigent" be limited to those services mandatorily required under the terms of the Federal Act, or include additional services permitted by the Federal Act?

At its start, the program should provide coverage for the "medically indigent" only with respect to appropriate elements, administratively determined by the board of control of the following seven services. The administering authority ought to have the discretion to add from time to time on a progressive basis, as appropriations are available, appropriate elements of all of the additional services required to be included by July 1, 1975:

1. Inpatient hospital services;

2. Outpatient hospital services;

3. Laboratory and x-ray services;

4. Skilled nursing home servcies;

5. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing home, or elsewhere.

6. Dental services, including dentures;

7. Inpatient hospital and skilled nursing home services for persons age 65 and over in tuberculous and psychiatric institutions.

8. Should the County Welfare Boards be utilized in the administration of the program?

The state administering authority should be permitted to purchase from county welfare boards the services of investigating and determining the financal elgibility of "indigent" persons not already receiving public assistance and of "medically indigent" persons.

9. Ought the services of fiscal intermediaries be utilized in the program?

The administering authority should exercise administrative discretion, in collaboration with other state authorities (such as the department of the treasury), to negotiate contracts for selected ministerial services by fiscal intermediaries or "carriers."

10. What mechanism would best enable the State to discharge its responsibilities to provide reasonable compensation to vendors of medical services?

There should be established outside the immediate jurisdiction of the department of institutions and agencies, a state government health economics unit, with authority to make such determinations. These would be binding on all state and local government units purchasing the same services.

Pharmacists' Liability For Substitution

The druggist who decides that an item he has in stock is just as good as one he is out of when filling a prescription opens an uncertain door that leaves him subject to liability suits. So said A. R. Christovich Jr., of the New Orleans law firm of Christovich and Kearney, in an address on druggists' liability at the annual meeting of the American Bar Association in August 1967.

Mr. Christovich called the substitution of an item in a prescription "one of the greatest dangers posed to this profession." He added that it is not for the druggist to judge in such circumstances and his actions leave him open to liability. Should a substitution be a mistake rather than an act committed by design, Mr. Christovich said, "the law places upon the druggist the obligation to inform the patron of the mistake immediately." Not to do so is negligence, he warned.

Courts also have held that a defense of illegibility of a prescription is not tenable, since if there is any doubt in the druggist's mind, he must check with the physician.

The druggist escapes liability, Mr. Christovich said, "where the medicine is delivered in its own sealed package," since courts have held that he is not required to analyze the contents of every bottle he buys and then sells. Thus, he added, there is a clearly evident rule of thumb for today's pharmacist: wherever possible, use the manufacturer's original packets in filling prescriptions. There are, however, cases in which packets must be opened and their contents mixed with other ingredients to make up a prescription.

In defining the duty owed by the druggists to the public, Mr. Christovich said: "The care to be exercised by the druggist in filling prescriptions is that used by ordinarily prudent and skillful men, in a like business and under similar circumstances." The key words, he said, are "in a like business and under similar circumstances." This he said, implied a special degree of responsibility because of the technical field involved.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of January:

	January 1968
Aseptic Meningitis	4
Hepatitis — Total	147
Infectious and Unknown	121
Serum	26
Malaria (Servicemen)	9
Measles	34
Meningococcal Meningitis	2
Mumps	761
Primary and Secondary syphilis	60
Salmonella	43
Shigella	8
German Measles	36

Influenza

As January ends, the influenza outbreak appears over in New Jersey. A_2 has been isolated from three separate throat washings and paired sera have confirmed infection with A_2 influenza in about 60 school children throughout the state. Influenza was first reported from Bergen County. It then spread in a south-westerly direction. A total of 142 schools reported absenteeism greater than 15 per cent due to an influenza-like illness in 16 out of 21 counties. The break down of the number of schools reporting excess absenteeism and date of the first report by week of the year and by county is as follows:

Week of	*County*	*Schools reporting excess absenteeism*
Dec. 4	Bergen	23
Dec. 18	Essex	42
Dec. 18	Union	18
Dec. 18	Passaic	1
Dec. 18	Middlesex	8
Dec. 18	Monmouth	7
Jan. 1	Hudson	11
Jan. 1	Ocean	6
Jan. 1	Morris	4
Jan. 1	Warren	1
Jan. 8	Mercer	9
Jan. 8	Gloucester	2
Jan. 8	Cape May	5
Jan. 8	Camden	3
Jan. 22	Cumberland	2
Jan. 22	Salem	1

The greatest number of cases were in counties nearest New York City, where influenza was considered to be of epidemic proportion. Of the schools reporting excess absenteeism, 32 per cent were high schools, seven per cent were Junior High Schools and 61 per cent were elementary schools. Rutgers and Princeton University saw sporadic cases of influenza and serologic results on the latter are pending.

Measles

Over 30 cases of measles were reported in New Jersey during January, 1968, Paterson and Newark account for two-thirds of these cases. According to the *Morbidity and Mortality Weekly Report* of January 20, 1968 (published by the National Communicable Disease Center), "For the first time since reporting of measles began on a national basis (1912), the reported cases in 1967 were fewer than 100 per 100,000 population. In 1967, the case rate per 100,000 population was 37.4 as compared to 104.2 in 1966." New Jersey had fewer than 25 cases per 100,000 population.

Mumps

Over the last four months an outbreak of mumps has occurred in an elementary school in rural Warren County. More than 100 cases have been reported from this school which has 370 students, giving an attack rate of 30 per cent. Although the history of previous mumps is about the same in the different grades, the attack rate during the current epidemic is much greater in the younger children, indicating that sub-clinical infection has occurred in the older students. The Communicable Disease Control Program is interested in hearing about other outbreaks of mumps.

202nd Annual Meeting

May 18-22, 1968

Haddon Hall, Atlantic City

Blue Plans' First Billion Dollars

New Jersey Blue Cross and Blue Shield passed some significant milestones during the year just ended, and the two non-profit health benefit plans are anticipating more of the same during 1968. Additionally, they are readying new ways to conserve the subscriber's dollar in the new year.

Each plan set new records in service and enrollment in 1967. In June, Blue Cross passed the billion dollar mark in hospital care benefits paid since organization in 1932 and, in November, its enrollment topped three million persons for the first time. Blue Shield, which marked its 25th anniversary during the year, added 100,000 new members and now has about 2.9 million enrolled.

Several unique programs have been developed by Blue Cross and Blue Shield to discipline the expenditure of the subscriber's health benefit dollar. A high degree of cooperation with Blue Cross and Blue Shield by hospitals and doctors (nurtured over decades of close association) has enabled the plans to pioneer measures to contain rising costs of care, to control duplication, and to prevent unnecessary hospital utilization.

A new method of determining payments to be made to physicians was developed by Blue Shield in 1967, called the "prevailing fee" concept. This will establish a range of fees for more than 1,300 medical-surgical procedures, compiled from data on their usual charges submitted by doctors, that will be accepted as full payment by doctors participating therein for services rendered to Blue Shield members enrolled in certain programs. The new program, available to multi-location national account groups, provides service benefits irrespective of whether the subscriber's income comes under specified limits, as is the case with Blue Shield's traditional concept. Both of the Blue Shield payment methods have built-in ceilings. This contrasts with the open-end approach by many other carriers in paying physicians, particularly under Medicare, which has been cited as a leading contributor to the escalation of health care costs.

Another means of stretching the subscriber's dollar has been through support of organized planning to prevent unneeded and duplicative hospital construction. Blue Cross and Blue Shield have contributed substantial support to the Health Facilities Planning Council for New Jersey which, along with regional councils in various areas of the state, screens proposed hospital and nursing home projects. Further, Blue Cross has backed up this much-needed effort to plan health facilities and services by refusing to include expansion or new building costs in its reimbursement formula unless such projects have received the approval of the regional planning councils. This provides the voluntary planning groups with their most potent weapon against unnecessary projects which would add to the ongoing inflation of health care costs.

Still another economy program, unique to Blue Cross and Blue Shield continued rolling along in high gear during 1967 and will be intensified in 1968. This is approval of Individual Diagnosis, called "AID," which requires the attending physician to sign a certification attesting to medical need for continued hospitalization of his patient after a set number of days. "AID" cut a half day off the average Blue Cross hospital stay during its first year and its enforcement will be intensified in 1968. This has the concurrence of the Medical Society and Hospital Association.

Blue Cross and Blue Shield, as the major New Jersey carriers specializing entirely in health benefits, have developed other means of guarding the dollar in their day-to-day business processes. Thus, benefits are denied as a matter of routine for test, rest cures, and other conditions not covered under the subscription certificate. The two plans have the state's most experienced staff of trained health claims examiners, and the Plans' present complement of more than 1,200 employees is expected to expand as new programs are added during 1968.

Among these, in addition to new lines of group and individual business, are governmental programs such as those in which the Blues have specialized for the past dozen years. Since the first designation of Blue Cross and Blue Shield to handle health benefits for dependents of servicemen back in 1956, Blue Cross has undertaken coverage of welfare categories such as OAA, MAA, Child Welfare, and the Blind under state-county programs, in addition to the Plan's well-known involvement in Medicare.

"Medicaid" for New Jersey is being discussed as a better than $200 million state-federal undertaking starting within the next two or three years. Blue Cross and Blue Shield have already become deeply involved in helping state welfare officials prepare for it. The State Department of Institutions and Agencies knows they are willing to serve as underwriter or intermediary on a basis similar to that which they have pioneered in the other government-sponsored health programs in the state.

Easter Seals

The National Society for Crippled Children and Adults (The Easter Seal Society) is the oldest and largest voluntary agency serving the handicapped in the United States. The Society attacks the problem of crippling with a nationwide program of treatment, research, and education.

Specialized treatment of the crippled is given through programs of 1,400 state and local affiliates in the 50 states. Services are adapted to community needs and include rehabilitation and treatment centers, sheltered workshops, home employment, resident and day camps, hospitals, itinerant, mobile, and home therapy. Treatment is given only by professional persons under medical direction. The Easter Seal Society employs 3,700 physical and occupational therapists, speech pathologists, camping and recreational specialists, administrators, and other rehabilitation personnel. A national Professional Advisory Council and state and local councils (made up of distinguished medical and rehabilitation authorities) advise in the conduct of service programs. Treatment and other services are given each year to a quarter million crippled children and adults.

Cost of the nationwide program was $22,724,760 in 1966. It is financed mainly by the voluntary contributions during the annual Easter Seal Campaign. Legacies and special gifts also constitute a substantial share. *Approximately 90 per cent of all funds are retained within the state where raised* to support programs for crippled children and adults.

Easter Seal societies at national, state, and local levels are governed by volunteer boards with a total membership of 30,000 men and women from all business and professional fields. In addition, 600,000 volunteers assist professional staff in fund raising, transportation of patients, camp counseling, and countless other tasks for the handicapped.

Through National Society scholarships and fellowships, doctors, physical and occupational therapists, speech pathologists, educators, and others in related fields have received advance training as part of the nationwide Easter Seal professional education program. Affiliate societies make similar awards. Broad educational programs through publications and films also are directed to the public, parents, and employers. The Easter Seal Research Foundation has made more than 250 grants, totalling more than two and a half million dollars to universities, medical schools, hospitals, and other research institutions since 1956.

Dr. Coes to Viet Nam

Harold V. Coes, M.D., a general practitioner in Sussex, and a member of that component medical society, last month began a 60-day period of voluntary service in Viet Nam.

Medicare Changes

Payment on Unpaid Bills

If no assignment is taken, medical insurance payments may now be made directly to the patient on the basis of an itemized bill—even though it has not been paid. This new provision applies to all bills received or processed by carriers on or after January, 1968, even though the services were rendered before that date.

Limit for Filing Medical Insurance Bills

For payment to be made on a bill, it must be submitted before December 31 of the year following the year in which services are received. Services received in the last 3 months of a calendar year are counted as received in the following year; thus, bills for such services may be submitted until December 31 of the second year after the year in which services were actually received.

A special extension permits bills for covered services received in July, August, or September, 1966, to be submitted until March 31, 1968.

Elimination of Certain Physician Certifications

Physician certification of medical necessity for outpatient hospital services and admissions to hospitals has been eliminated. The provision applies to admissions and to outpatient services furnished on and after January, 1968. The first certification for inpatient services in a general hospital will now be required as of the 14th day of services. Initial certification is still required for admissions to psychiatric and tuberculosis hospitals and to extended care facilities.

Additional Inpatient Hospital Benefit Days

Each hospital insurance beneficiary will have a "lifetime reserve" of 60 additional days of inpatient hospital coverage. These additional days can be used at the patient's option whenever the 90 days covered in a "spell of illness" have been exhausted, and are subject to $20 a day coinsurance. This benefit is not renewable; the number of days in a beneficiary's "lifetime reserve" is permanently reduced by the number of days used.

If the beneficiary is an inpatient of a participating hospital on January 1, 1968, and has previously exhausted his inpatient hospital benefits, the lifetime reserve days can be drawn on immediately.

Radiology and Pathology Services to Hospital Inpatients

Payment of the full reasonable charges may be made under medical insurance for radiology and pathology services furnished by physicians to inpatients of participating hospitals. The $50 annual deductible does not have to be met.

It will also be possible to pay for radiology and pathology services to hospital inpatients in a manner that is more consistent with the usual billing procedures of many hospitals and the manner in which these services are reimbursed by most other health insurance programs. Where the hospital customarily bills for both the hospital's services and the services of the pathologists and radiologists, the absence of the medical insurance deductible and coinsurance will now make it unnecessary to break down the bill on a patient-by-patient basis into the parts covered under the hospital insurance and medical insurance programs, since this can be done on an aggregate basis. Thus, where the total services are billed through the hospital, the provision would provide opportunities for the development of hospital billing procedures that will greatly reduce paperwork and facilitate administration.

Outpatient Hospital Benefits Under Medical Insurance

There will be only a single deductible and coinsurance applied to all covered outpatient hospital services (the $50 annual medical insurance deductible and 20 per cent coinsurance), and no need to separate diagnostic

from therapeutic services as in the past, for allocation of costs and charges to different parts of the Medicare program. Hospitals may, in situations described in regulations, collect an outpatient charge of $50 or less from the beneficiary. This will simplify hospital collection processes in situations where the hospital cannot readily determine whether the patient has met the deductible, and he is able to pay the bill at the time services are rendered. Where such collections are made, the beneficiary would ordinarily receive the medical insurance reimbursement on the basis of a claim prepared on his behalf by the hospital. Payments to the hospital will be periodically adjusted to assure that total hospital reimbursement for outpatient services does not exceed what the hospital would have received if it had submitted all bills on a cost reimbursement basis.

Additional Outpatient Physical Therapy Services

At present, physical therapy services are covered when furnished under the direct supervision of a physician, or to homebound patients under a home health plan. Effective July 1, 1968, physical therapy services will also be covered when furnished by qualified providers under arrangements with, and under the supervision of, such providers. The term "providers of services" includes clinics, rehabilitation agencies, and public health agencies. For payment to be made for such services, a physician must certify that the patient requires physical therapy services on an outpatient basis, and is under a plan of treatment established and periodically reviewed by a physician which prescribes the type, amount, and duration of the services. The patient does not need to be confined to his home.

Ancillary Services Not Payable Under Hospital Insurance

Payment can be made under medical insurance for certain ancillary services furnished by a hospital or extended care facility for which no payment can be made under hospital insurance. This provision would apply, for example, where a patient has exhausted his hospital insurance eligibility or where an extended care facility patient has not met the prior hospitalization requirement. These benefits are subject to the $50 deductible and 20 per cent coinsurance.

California: Here You Come!

June 16, 1968 is the opening day of the AMA Convention in San Francisco. Thus, the excitement of that city's famous sites is waiting for you—Chinatown, the Golden Gate Bridge, Fisherman's Warf, Telegraph Hill – and will add to five memorable and stimulating convention days. Plan to attend now and look forward to an excellent convention in a city of unlimited charm.

Continue your graduate education with a varied program – four General Scientific Meetings on Auto Accidents, Health Care Planning, Infectious Diseases, and Treatment of Advanced Malignant Disease – twenty-three Section Programs – Color Television – Medical Motion Pictures – over 600 scientific and industrial exhibits – all are designed to bring you up-to-date on what is making medical news today. You will attend lectures by the nation's outstanding medical authorities and discuss with them the significant advances in medicine. In addition, the AMA TV network will present more than 40 hours of convention news.

New Diet Manual

The revised State Diet Manual has been completed and is now ready for distribution. Our Society participated in the preparation, and is interested in promoting its use by physicians, nursing agencies, and hospital and extended care facility dieticians.

To receive your copy, send a personal check or money order for $2, payable to the New Jersey State Department of Health, Division of Chronic Illness, P.O. Box 1540, Trenton, New Jersey 08625

ANNOUNCEMENTS

New Jersey Chest Physicians

A meeting of the New Jersey Chapter of the American College of Chest Physicians will be held on Sunday, March 31 at the Monmouth Medical Center, Third and Pavilion Avenues in Long Branch. The program starts promptly at 2 p.m., and the topic for discussion will be physiological and clinical aspects of IPPB. The speakers are Dr. Gustav J. Beck of New York and Dr. Peter A. Theodos of Philadelphia. Demonstrations of Bennett and Bird equipment are to be presented. For further information contact the chairman of the Program Committee, Dr. Alan J. Stolow, 235 Grove Street, Somerville 08876.

School Physicians' Graduate Courses

The second annual post-graduate course for school physicians will be held on April 10, 17, and 24 at the Labor Education Center of Rutgers University. Fred V. Hein, Director of the AMA's Department of Health Education, will be the keynote speaker. Topics to be covered include, "Making Sense Out of Psychological Tests," "Sex and the School Teacher," "Communications Problems," and many others. Registration forms may be obtained from Thomas P. McFarland, M.D., 110 West Main Street, Mays Landing 08330

Graduate Courses in Florida

A chance to combine graduate medical learning with a trip to Florida is offered by the Mound Park Hospital in St. Petersburg, Florida. "Gastric Psychiatry" is the unique title of a unique course in the psychosomatics of gastro-intestinal diseases. This program is on May 2, 3 and 4, 1968. The Hospital also offers a three-day intensive course in correlations of laboratory and clinical findings on April 11, 12, and 13. AAGP credit is given for either or both courses. For details write to M. A. Barton, M.D., Mound Park Hospital, St. Petersburg, Florida 33701.

Chicago Graduate Course on Fractures and Other Trauma

From April 17th to April 20th, 1968, the Chicago Committee on Trauma will present its Twelfth Graduate Course on Fractures and Other Trauma. It will include abdominal, thoracic, genito-urinary, ophthalmologic, neurosurgical, and vascular trauma, as well as musculo-skeletal trauma.

The four-day course will be given at the Murphy Memorial Auditorium, 50 East Erie Street, Chicago 60611. The course is open to all doctors. Registration fee, which is $80 includes the Chairman's reception one evening, and luncheon on one of the meeting days. Residents and interns will be admitted free upon presentation of a letter from their chief of service. The American Academy of General Practice gives credits to members who take the course. Registration can be accomplished by writing to Chairman, Twelfth Graduate Course, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611. Reservations at one of the many nearby hotels should be made individually and separately.

Contact Lens Course

An advanced course in contact lens technology is announced by the New York Eye and Ear Infirmary for May 1968. This will be held on Sunday, May 19, 1968 at the Gramercy Park Hotel which is where 21st Street, New York City, crosses Lexington Avenue. In this program, special attention will be paid to detrimental effects on the cornea, to the problem of contact lenses for children, to the development and control of keratoconus, and to clinical problems in optics. The primary appeal of this course will be to ophthalmologists, but pediatricians will find much of interest in the discussion of contact lenses for children — even, indeed for infants. The fee is $50, but it is well worth it.

Luncheon is included without extra charge. For a specific time-table, for registration, and more information, write to: Registrar, Institute of Ophthalmology, Eye and Ear Infirmary, 218 Second Avenue, New York, New York 10003.

Trip to Hawaii and Japan for Author of Prize-Winning Paper

The intern, graduate student, or resident who writes the best paper on obstetrics or gynecology may win a free trip to Japan and Hawaii to present his paper to the International Colleg of Surgeons in Hawaii on September 29th, and in Tokyo on October 7th. For more details, write to Dr. H. A. Gollin, 55 East Washington Street, Chicago 60602.

Electroencephalography Course

If you can get to San Francisco on September 9th, you can take a course in clinical electroencephalography, sponsored by the American EEG Society and supported by a grant from the United States Public Health Service. For more details, write to Dr. Donald W. Klass, EEG Director, Mayo Clinic, Rochester, Minnesota 55901.

Otolaryngology Courses in Chicago

On October 10 and 11, a special program on head and neck radiology is scheduled for the Illinois Eye and Ear Infirmary in Chicago. And a longer but intensive course in otolaryngology is planned to start on October 12, 1968. For details, write to the Department of Otolaryngology, Illinois Eye and Ear Infirmary, P.O. Box 6998, Chicago 60680.

Annual Meeting
May 18-22, 1968

Camp For Diabetic Children

A medically supervised summer camp for diabetic children is located in Middletown, New York. It is called Camp Nyda (which, one suspects, is an acronym for New York Diabetes Association), and accepts diabetic children between the ages 6 and 15. This is its 33rd year and it has happy alumni all over the east. If you have a patient who can be helped by a summer in the country, write for details to Camp Nyda, New York Diabetes Association at 104 East 40th Street, New York 10016.

How to Keep Up With Medicine

Once a year, you have an opportunity to spend the better part of a week doing nothing but "keeping up" at the world's largest medical meeting, the Convention of the American Medical Association. The next great parliament of American Medicine will be held June 16 to 20 in San Francisco. The Civic Auditorium, the Opera House, and nearby hotels will house the scientific program. The House of Delegates will meet in the Fairmont Hotel.

Some 600 scientific papers will be presented, and more than 250 scientific exhibits will be on display. Among special presentations are four scientific meetings on automobile accidents, health care planning, management of infectious diseases, and treatment of advance malignant disease.

Also being programed are 23 scientific sections which will offer agenda individually, many holding joint meetings on subjects of common interest.

A full schedule of medical motion pictures is planned, as is a program of live color telecasting from a San Francisco-area medical center.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1968
March

12 **The Academy of Medicine of New Jersey with American Cancer Society (New Jersey Division)**
Institute for Medical Research
Camden
Symposium: "Cancer of Colon and Rectum"

12 **Bergen County Medical Society**

12 **Essex County Medical Society**
Hotel Suburban, East Orange
"What Can An Office Consultant Do For You?"

12 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Islet Cell Tumors of the Pancreas and Syndromes Associated With Them"

13 **Ocean County Medical Society**

13 **Gloucester County Tuberculosis and Health Association**

13 **The Academy of Medicine of New Jersey**
Mountainside Hospital, Montclair
Symposium on Supraventricular Arrhythmias

13 **Middlesex General Hospital**
New Brunswick
Symposium: "Management of Acute Leukemias"

13 **The Academy of Medicine of New Jersey — Section on Internal Medicine**
Peter Bent Brigham Hospital
Boston
Symposium on Steroids

15 **The Academy of Medicine of New Jersey**
(With Gloucester, Salem and Cumberland County Medical Societies)
Salem County Memorial Hospital
Salem
Symposium: "Oral Contraceptives"

15 **Cooper Hospital**
Camden
"Collagen Disease"

19 **The Academy of Medicine of New Jersey and American Cancer Society (New Jersey Division)**
Newcomb Hospital, Vineland
Symposium: Cancer of the Colon and Rectum

19 **The Academy of Medicine of New Jersey**
Newton Memorial Hospital, Newton
Symposium: "Intensive Care of the Cardiac"

19 **Passaic County Heart Association**
Annual Meyer Notkin Lecture

20 **Middlesex County Medical Society**

20 **Middlesex General Hospital**
New Brunswick
Symposium: "End Results of Treatment of Breast Cancer"

21 **Morris County Medical Society**

21 **The Academy of Medicine of New Jersey — Section on Urology**
Annual William Burpeau Award
Dinner—Mayfair Farms, West Orange
"New Concepts in Urinary Infection"

22 **Cooper Hospital**
Camden
"When to Hospitalize the Diabetic"

23 **New Jersey State Society of Anesthesiologists**
Cherry Hill Inn, Cherry Hill
9th Annual Postgraduate Seminar

26 **Cape May County Medical Society**

26 **The Academy of Medicine of New Jersey**
Jersey Shore Medical Center
Neptune
Symposium: "Hypertension and Kidney Disease in Pregnancy"

26 **The Academy of Medicine of New Jersey**
Newton Memorial Hospital, Newton
Symposium: "Acute and Chronic Care of the Alcoholic"

27 **The Academy of Medicine of New Jersey — Section on Dentistry**
Mercer Hospital, Trenton
"Psychological Effects of Medical and Dental Treatment on Children"

27 **Princeton Hospital**
Princeton
"Management of Turnpike Trauma—Role of the Physician and Surgeon"

27 **Middlesex General Hospital**
New Brunswick
Symposium: "Management of Early and Late Breast Cancer in Relation to Surgery"

27 **New Jersey Heart Association**
Annual Scientific Seminar

29 **Cooper Hospital**
Camden
"Detection and Long-Term Management of the Ambulatory Diabetic Patient"

April

2 **Hudson County Medical Society**
"Some Psychiatric Problems of Childhood and Adolescence"

3 **The Academy of Medicine of New Jersey**
Princeton Inn, Princeton
Symposium on Adolescence

2 **The Academy of Medicine of New Jersey**
Newton Memorial Hospital, Newton
Symposium: "Congestive Heart Failure"

5 **Cooper Hospital**
Camden
"Modern Trends in the Treatment of Leukemia"

9 **Bergen County Medical Society**

9 **Cumberland County Medical Society**

9 **The Academy of Medicine of New Jersey**
Newton Memorial Hospital, Newton
"Problems of Oral Contraceptives"

9 **The Academy of Medicine of New Jersey — Section on Radiology**
Veterans Administration Hospital
East Orange
Presentation of Interesting Radiologic Cases of the Genito-Urinary Tract

9 **The Academy of Medicine of New Jersey — Section on Dermatology**
"Special Surgical Technics for the Dermatologist"

10 **Ocean County Medical Society**

10 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Biochemical Pharmacology And The Brain"

10 **Gloucester County Tuberculosis and Health Association**

12 **Cooper Hospital**
Camden
"What's New in Dermatology?"

16 **Warren County Medical Society**

17 **Middlesex County Medical Society**

17 **Newark Beth Israel Hospital**
Newark
"Mechanics and Management of Cardiogenic Shock"

18 **The Academy of Medicine of New Jersey**
Burlington County Memorial Hospital, Mt. Holly
Symposium: "Gastrointestinal Malignancies"

18 **Morris County Medical Society**

18 **Gloucester County Medical Society**

19 **Cooper Hospital**
Camden
"Chromosome Aberration in Old Age and Malignancy"

24 **The Academy of Medicine of New Jersey**
Veterans Administration Hospital
East Orange
Dental Symposium: "Clinical Periodontics — Recent Advances"

26 **Cooper Hospital**
Camden
"Immunity—Its Role in Health and Disease"

May

1 **Camden County Medical Society**

1 **The Academy of Medicine of New Jersey with American Cancer Society (New Jersey Division)**
Trenton County Club
Symposium: "Cancer of Colon and Rectum"

1 **Passaic County Heart Association**
Symposium on New Concepts in Cardio-Vascular Disease

7 **Hudson County Medical Society**
Election of Officers

8 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Drugs, Poisons, and Membrane Phenomena"

8 **Ocean County Medical Society**

8 **Gloucester County Tuberculosis and Health Association**

8 **Middlesex County Medical Society**

9 **Essex County Medical Society**

14 **Bergen County Medical Society**

16 **The Academy of Medicine of New Jersey — Section on Radiology**
Newark City Hospital
Radiologic Cases

16 **Morris County Medical Society**

16 **Gloucester County Medical Society**

18-22 **The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Annual Meeting

19 **The Academy of Medicine of New Jersey and The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Symposium on Medicine and Religion

28 **Cape May County Medical Society**

June

6-7 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Culdoscopy

11 **Ocean County Medical Society**

11 **Bergen County Medical Society**

11 **Cumberland County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"The Thymus — Its Role in Immunity and Disease"

18 **Warren County Medical Society**

20 **Morris County Medical Society**

Group Practice Guidelines

The third revision of *Group Practice: Guidelines to Forming or Joining a Medical Group,* is now off the presses. As a medical practitioner, you may obtain a complimentary copy by writing the Department of Health Care Services, American Medical Association. Jointly produced by the AMA, the American Association of Medical Clinics, and the Medical Group Management Association, the 40-page booklet covers all aspects of group practice.

OBITUARIES

Dr. LeRoy W. Black

With the death of Dr. LeRoy W. Black on January 6, 1968, New Jersey lost one of its pioneer cardiologists. Born in 1897, he received his baccalaureate degree at Brown and his M.D. at Cornell in 1924. He served in the U.S. Navy in 1918 and 1919. He was an internist, board-certified in that field, and was, indeed, the New Jersey "governor" for the American College of Physicians. Dr. Black became affiliated with the Hackensack Hospital in 1926, going through all ranks and becoming chief of internal medicine there in 1938.

Dr. Louis S. Downs

Dr. Louis Sheppard Downs, a prominent Middlesex County family doctor, died on January 21, 1968 at the age of 65. Born in Middlesex County in 1903, he received his M.D. degree at the medical school of St. Louis University in 1930. He interned at the Perth Amboy General Hospital and did general practice in Carteret until 1944, when he entered the medical corps of the Army of the United States as a Captain. On being demobilized in 1946, he returned to serving the people of Union and Middlesex Counties. He was affiliated with both the Perth Amboy General and St. Elizabeth's Hospitals. Dr. Downs was active in the affairs our Middlesex County Component Medical Society.

Dr. Joseph T. Salvatore

At the untimely age of 56, death came on January 18, 1968 to Dr. Joseph T. Salvatore, a prominent Trenton surgeon. Born and brought up in Trenton, he received his baccalaureate degree at the College of St. Joseph in 1935, and his M.D. at Jefferson Medical College in 1939. He then went to the graduate school of the University of Pennsylvania, acquiring an M.Sc. in surgery. Dr. Salvatore was a Fellow of the American College of Surgeons, and on the surgical staff of the St. Francis Hospital in Trenton.

Dr. Benjamin Seiler

A leader in medical, religious, and civic affairs in the Hasbouck Heights area, Dr. Benjamin Seiler died on January 21, 1968 at the age of 66. He won his M.D. degree at the medical school of George Washington University in 1927. Dr. Seiler was a general surgeon, who was a Fellow of the American Academy of Abdominal Surgeons and on the surgical staff of the Hasbrouck Heights Hospital. He was one of the founders of the Temple Israel in Cliffside Park and participated actively in civic affairs throughout Bergen County. Dr. Seiler was a member of the Bergen County Medical Society.

Dr. Leon Tisch

Thirty years of devoted service to the people of Middlesex County came to an end on January 6, 1968 with the death that day of Leon Tisch, M.D. of Highland Park. Born in Austria in 1905, Dr. Tisch earned his M.D. at the German Medical Faculty in Prague in 1931. Following the Nazi invasion of Austria, he left Europe in 1936 and came to the United States. He passed the New Jersey State Board examinations and in 1938 was granted a New Jersey license. Dr. Tisch was active in the New Jersey Academy of General Practice and in the affairs of the Middlesex County Society.

Dr. Charles H. Waters

On February 4th, at the age of 90, death claimed Charles Huff Waters, M.D., a former general practitioner from Trenton. Dr. Waters earned his M.D. from the University of Pennsylvania in 1901, and proudly served as "family doctor" to many in the Trenton area until his retirement two years ago. He had been affiliated with the Mercer Hospital in Trenton. At the time of his death, Dr. Waters was residing in Toms River.

BOOK REVIEWS

Neuropsychiatry in World War II. (Vol. I) Edited by Colonel A. J. Glass, M.C. and Lieutenant Colonel R. J. Bernucci, Washington, D.C., 1967, Department of the Army. Pp. 898. ($7.50)

At the begnning of World War II, it was hoped that potential psychiatric casualties could be screened out by meticulous pre-induction psychiatric studies. It didn't work that way, and today some 200,000 veterans of that war have service-connected disabilities for psychiatric or neurologic disorders. And during World War II, Army psychiatrists learned some salutary lessons — one of which was the deleterious effect of prolonged hospitalization. Another was the overlapping of the concepts of psychosis, character disorder, and goldbricking. Lessons were learned with respect to the orientation and training of neurologists and psychiatrists, the problems of nomenclature, the thorny issue of administrative vs medical discharge, and the possibilities of group therapy and narcosynthesis. This heavy volume is a record of the successes — and frustations — of military psychiatry as seen in the zone of the interior. The next volume will record the experiences of army psychiatry in the combat and communications zones.

There are chapters on the role of the psychiatric nurse, the psychologist, the social worker, the chaplain, and the occupational therapist. As with many military publications, there is emphasis on tabulations (this book has 67 tables!), charts, graphs, and statistical material. The text includes useful material on the postwar adjustment of psychiatric casualties, on the Women's Army Corps, on determination of line-of-duty (what the VA would later call service-connection), on the actual treatment technics used, and on every other aspects of military psychiatry and neurology. To the veteran of the service, this volume will be both useful and nostalgic. To the entering officer, it will be helpful and probably prophetic. The writing is smooth and readable, without the stuffiness that too often is associated with high-level military writing style.

Ulysses M. Frank, M.D.

The Human Adrenal Cortex (Ciba Foundation Study). Edited by G. E. W. Wolstenholme and Ruth Porter. Boston, 1967, Little, Brown and Company. Pp. 146. Illustrations 26. (Price not stated)

Here is another of the Ciba Foundation Study Group publications, this one dealing with the function of the adrenal cortex throughout life. The monograph is both comprehensive and informative. Reading is difficult due to the frequent references which are generously sprinkled throughout the text. Subjects discussed concern adrenal function during fetal life, childhood, and adolescence. There is an interesting discourse on the adrenal relation to pregnancy. Other papers review the gland during periods of medical and surgical stress and during the senium and the terminal phases of life. This is an interesting and informative book but of little direct use in the clinical practice of medicine.

Earl Kanter, M.D.

Clinical Hematology (6th Edition). Maxwell M. Wintrobe, M.D. Philadelphia, 1967, Lea and Febiger. Pp. 1287. Illustrations 278. ($22.50)

The latest edition of this classic contains 136 additional pages and weighs almost five pounds. It is suggested that the editors consider a two volume format in the future. Throughout the text, the most recent advances are included, allowing, of course, for the unavoidable absence of some of the very recent and usually still unproved innovations, e.g. treatment of acute leukemia with l-asparaginase. It is a pleasure to review this remarkably exhaustive treatment of what is probably the broadest and most complex "subject" in the field of medicine. As thematology spans all of medicine, it ought to be obvious that an up-to-date text such as Wintrobe's should be on every physician's reference shelf.

Every chapter has been revised more or less and updated as have the references, which thoroughly cover the period 1961 through early 1967 in addition to the earlier ones retained from the fifth edition. The reviewer noted many new good, clear color and black and white illustrations and found the author's practice of pointing out the gaps in our knowledge stimulating and worthwhile. The more significant additions include; recent thinkng as to cell origin and blood cell interrelationship based on more current knowledge of RNNA and DNA synthesis and function; cell culture and electronmicroscopy; much new data on the chemical composition of red blood cells; cytogenetics; iron metabolism and hemoglobinopathies; paraproteinmias; extensive revision of section on hemostasis and coagulation, blood volume, blood groups, transfusion, and macrocytic anemias; current views as to etiology and therapy of leukemia and other neoplastic diseases of the blood forming organs and reticuloendothelial system. The latest recognized methods of testing for the various disorders are touched upon but generally not described in great detail as the text is not intended to serve as a laboratory bench manual.

In summary: well worth $22.50, and a significant improvement over the excellent fifth edition.

Harry H. Stumpf, M.D.

Resources For The Retarded In New Jersey. Fifth Edition. New Jersey Association for Retarded Children, 1967, New Brunswick, New Jersey. Pp. 137, plus directory. ($2)

As indicated in the foreward (written by Elizabeth Boggs, past president of the National Association for Retarded Children), this edition is drastically revised, broadened in scope, made more complete and updated. It has added a comprehensive directory of all available services by county (in a 20 page appendix). It is geared not only to physicians, teachers, social workers, nurses, students, labor leaders, legislators' aides, county officials, school board members, civic leaders, and others who are faced with the duty of assisting afflicted families, but to the parents as well.

While such items as "The Causes of Mental Retardation" are dealt with in only a summary fashion, a description and listing of diagnostic and evaluation facilities are catalogued, giving such useful facts as territory covered, fee range, hours and days, and telephone numbers.

Included throughout the several chapters is a colorful historical perspective, reminding us of such New Jersey firsts as: the adaptation of the Binet-Simon test; the development of the Vineland Social Maturity Scale by

Edgar Doll; the first diagnostic and evaluation service expressly for the retarded by the Essex Unit in 1949; and special education classes as early as 1905.

However, the bulk of this compendium, in a highly professional manner, deals with such basic information as: day care, residential care, special education classes, vocational rehabilitation, recreation (including camps), counseling, and social services; with a particularly timely addition of practical information about guardianship, income maintenance, and insurance coverage. For the more politically oriented, past, present, and future legislation is briefly and cogently summarized. The intricate interrelationships and divided responsibilities between the various agencies, state and local, are carefully drawn with charts and tables.

Just in case this was not enough, someone has cleverly thought up questions on all of these subjects — and answers them.

No one who has even a peripheral interest in the subject should be without this resource.

BERNARD R. GOLDBERG, M.D.

Symposium on Glaucoma (Transactions of the New Orleans Academy of Ophthalmology) St. Louis, 1967, C. V. Mosby, Pp. 306. Illustrated. ($17.50)

This is the record of the third of fifteen annual sessions dealing with glaucoma. Since that time, there have been many advances, including understanding of inheritance patterns, instrumentation, and more powerful drugs for treatment. All these topics and more are presented in this book which gives the clinical opthalmologist up-to-date information on glaucoma.

Each panelist discusses one or more subjects in detail. A round table discussion featuring answers to questions from the audience closes the meeting. A new feature this year is a report of six cases with emphasis on criticism of prior treatment, suggestions for future handling and other diagnostic possibilities.

A chapter on the outflow channels reviews current knowledge of the anatomy of the glaucomatous eye, with speculation as to the basic cause of congenital glaucoma and primary open angle glaucoma. Two new recently discovered kinds of glaucoma are discussed in detail; enzyme glaucoma (alpha-chymotrysin), and glaucoma after trauma. The new Mackay-Marg tonometer is compared with the Goldman applanation tonometer and for most purposes the former comes off second best. Discussion of provocative tests for open angle glaucoma is limited to the water provocative tonogram which (some investigators feel) introduces so many variables that its interpretation leaves much to be desired.

There is an important chapter by Dr. Mansour Armaly on the relationship of steroids to glaucoma. Dr. Armaly has done original work in this field and describes the genetic implications of his studies. Chapters on the miotics, topical epinephrine and hyperosmotic agents bring out much new information essential for any ophthalmologist who wants to avoid complications and who wants to be aware of side effects in treating glaucoma patients. These include the development of iatrogenic cataracts from the long-acting anticholinesterases, and the retinal changes from topical use of epinephrine.

This book is heartily recommended for reading and reference.

ARTHUR S. KERN, M.D.

Advances in the Treatment of Poisoning. Jay M. Arena, M.D., Editor. **Treatment of Mental Retardation, Part I.** Charles M. Poser, M.D., Editor. (Modern Treatment, Vol. 4, #4) New York, 1967, Hoeber Medical Division, Harper and Row. ($16 per year by subscription)

Dr. Arena's symposium commands our attention on several counts. There are one million cases of poisoning per year in the United States, probably an understated figure. Child deaths from poisoning exceed the total of measles, poliomyelitis, scarlet fever, and diphtheria combined. The contributions are incisive and thorough, ranging from general principles of symptomatic and supportive care to detailed therapy of the more common intoxications, such of salicylates. barbiturates, lead, and insectisides. This text is highly recommended as an excellent reference for anyone who treats patients. "No one is immune to an emergency call when poisoning has occurred, regardless of his specialty."

In the second half of this volume mental retardation receives careful attention. Emphasis is on "common sense and compassion." Interesting features of diagnosis include pseudoretardation from non-neurologic causes such as malnutrition, prolonged illness, emotional and cultural deprivation; and remediable retardation amenable to specific treatment, such as chronic subdural hematoma and poorly controlled or unrecognized subclinical epilepsy. Management is approached with guarded optimism. Custodial care is felt best reserved for the severely handicapped. The majority of retardates can be trained, using home care and community facilities. This portion of the symposium includes a brief section on genetic investigation and counseling.

LAWRENCE SILVERMAN, M.D.

Alcoholism. Edited by Ruth Fox, M.D. New York, 1967, Springer Publishing Company. Pp. 340. (Price not stated)

Offered here is an anthology of papers and articles representing practically every discipline and field interested in alcoholism. Physiologic, psychologic-behavioral, as well as analytic-sociologic, anthrapologic, and theologic approaches are explored. The views of the alcoholic himself are solicited. The material is exhaustive and complex; much is theory and speculation, contradictory and diverse, but informative. We are free to reach our own conclusions. We read not about alcoholism alone, but also of the many related matters associated with it, including its prevention.

The therapies described are even more bewildering. They include occupational and psychotherapies, the aversion and conditioning technics, the tranquilizers, and L.S.D. They are thoroughly discussed, criticized, and defended. Motivation, however, is still held to be the key to successful management. If the patient lacks motivation, perhaps it can be kindled. Ways of accomplishing this awakening are suggested and outlined. The doctor, the family, the community, the hospital, the clergy, and the nurse all have their special roles. Alcoholism is a many faceted illness which must be treated by a multiple approach.

Dr. Fox points out that the common denominator that emerges is this: "getting across to the isolated, self-loathing alcoholic the feeling that the therapist does really consider him a worthwhile person who can be helped." Helped he can be, and the message that somehow filters through the maze of writing, is to be alert to all the means to accomplish this end.

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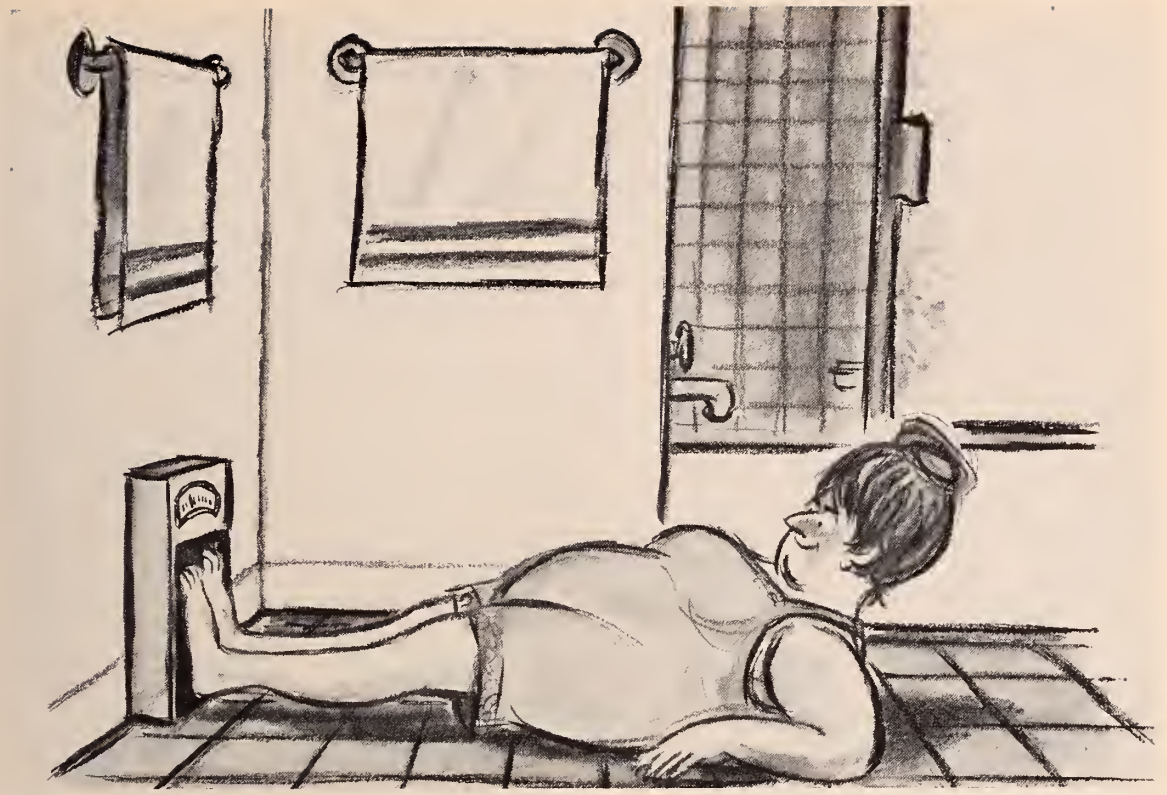
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(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27—Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology *89*:438-443 (Sept.) 1967.

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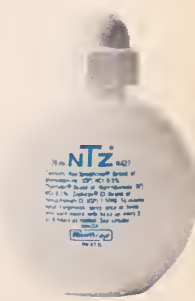
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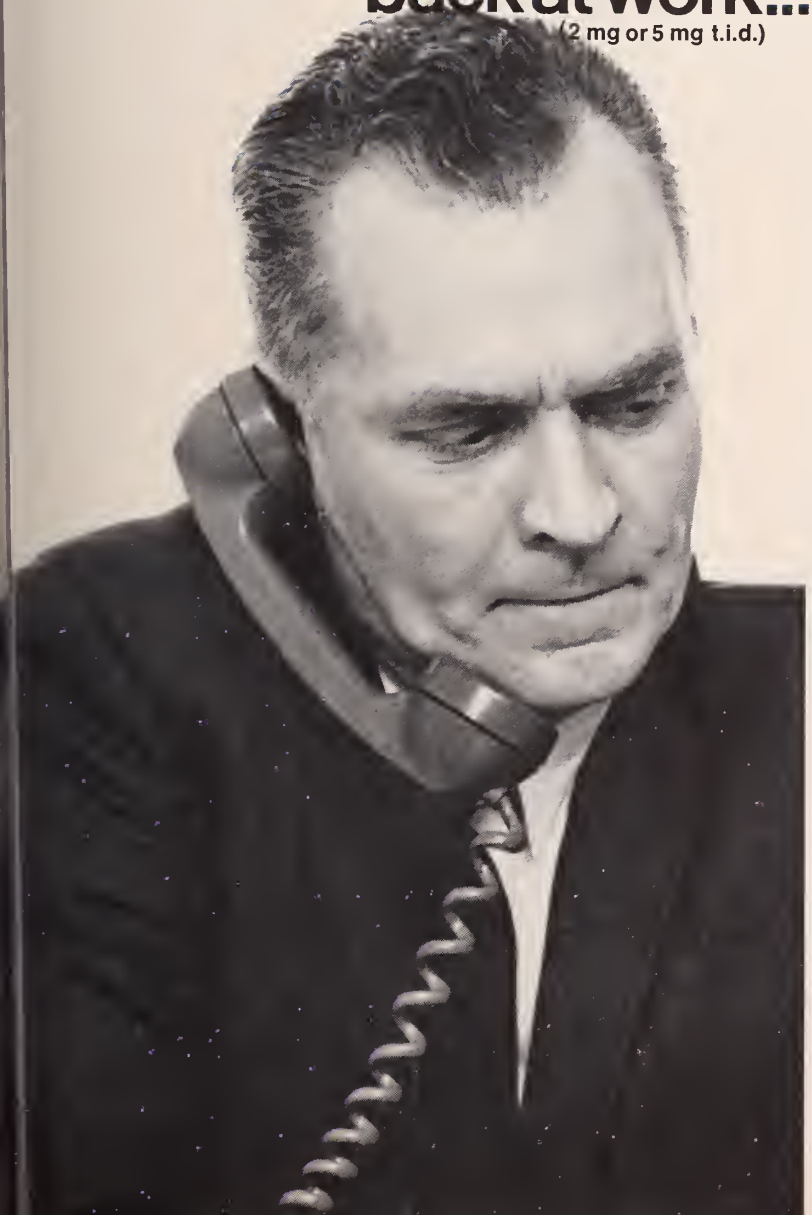


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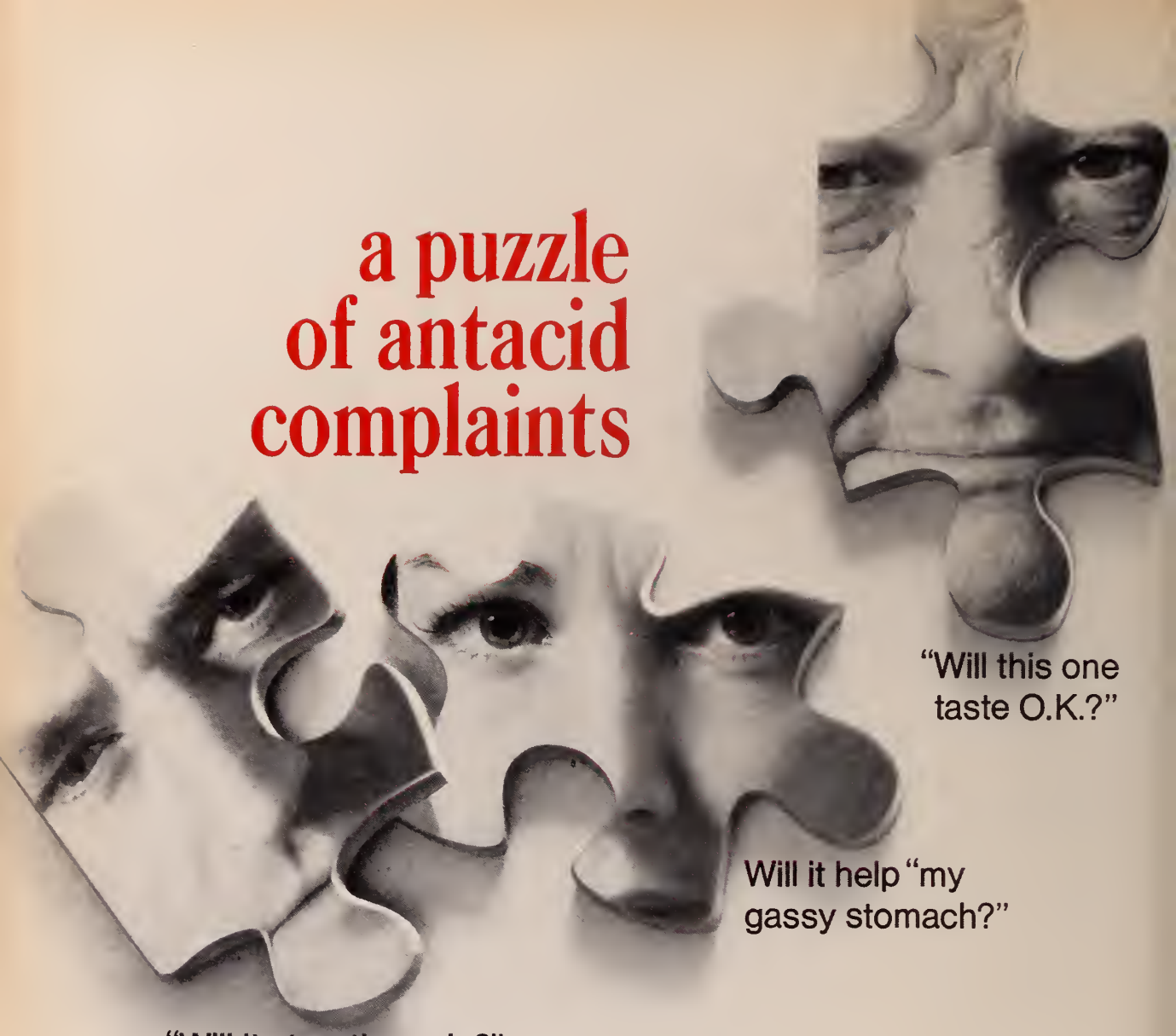
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References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

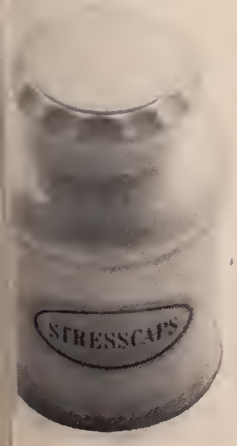
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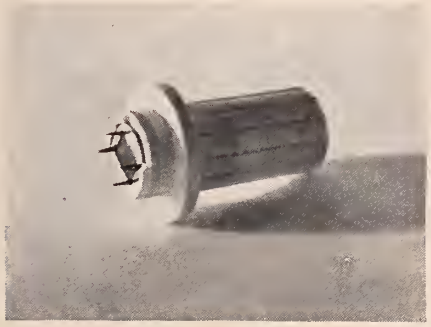
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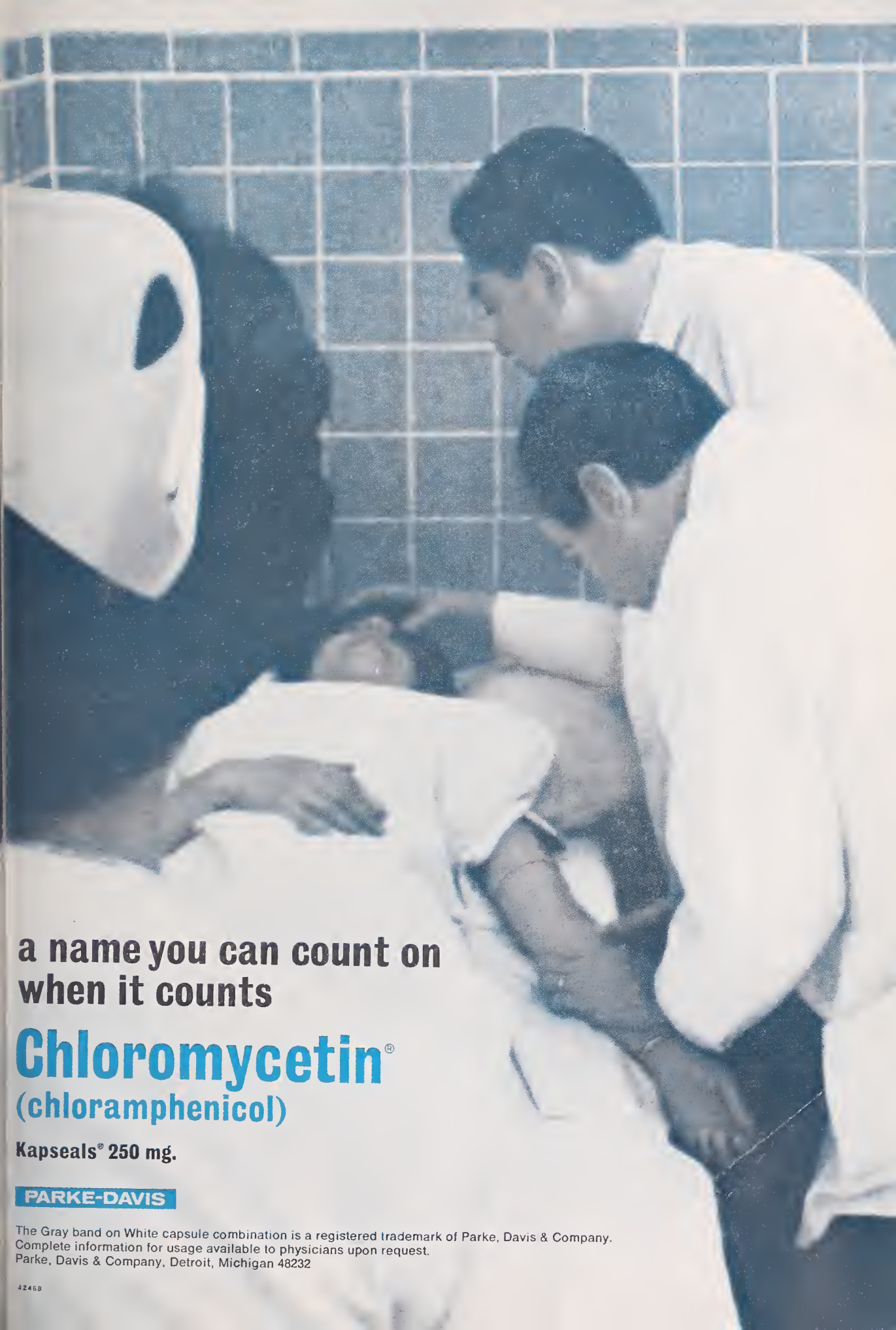
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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APRIL 1968
VOL. 65, NO. 4

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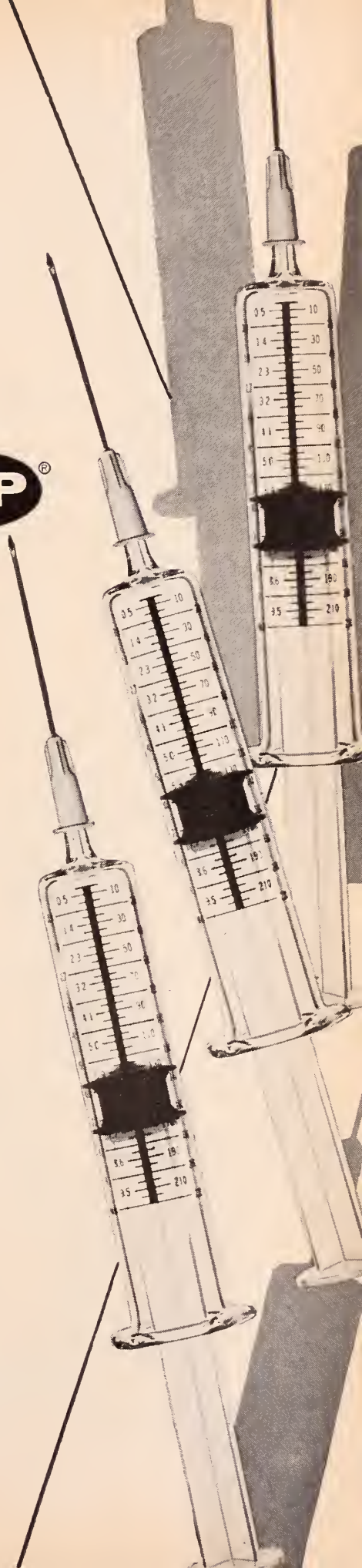
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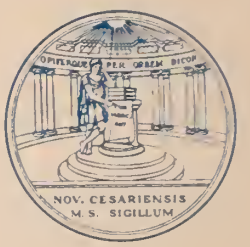
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THE JOURNAL is published monthly (since 1904) by The Medical Society of New Jersey — under the direction of the Publication Committee — 315 West State Street, Trenton, New Jersey. Phone: 394-3154 (Area Code 609); Printed and Published at Periodical Press, 3rd and Hunting Park Avenues, Philadelphia, Pennsylvania.

SUBSCRIPTION RATES — Price per year in advance, including postage: United States, $5. Foreign, $5, plus postage.

SINGLE COPIES—50 cents each. If more than two years old, $1 each.

Second-class postage paid at Philadelphia. Address all communications for publication to P. O. Box 904, Trenton, New Jersey 08605.

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Prescribing information on next page.

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DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines when the offending organisms are tetracycline-sensitive.

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Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occure. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth— dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected.

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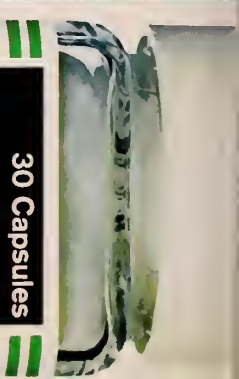


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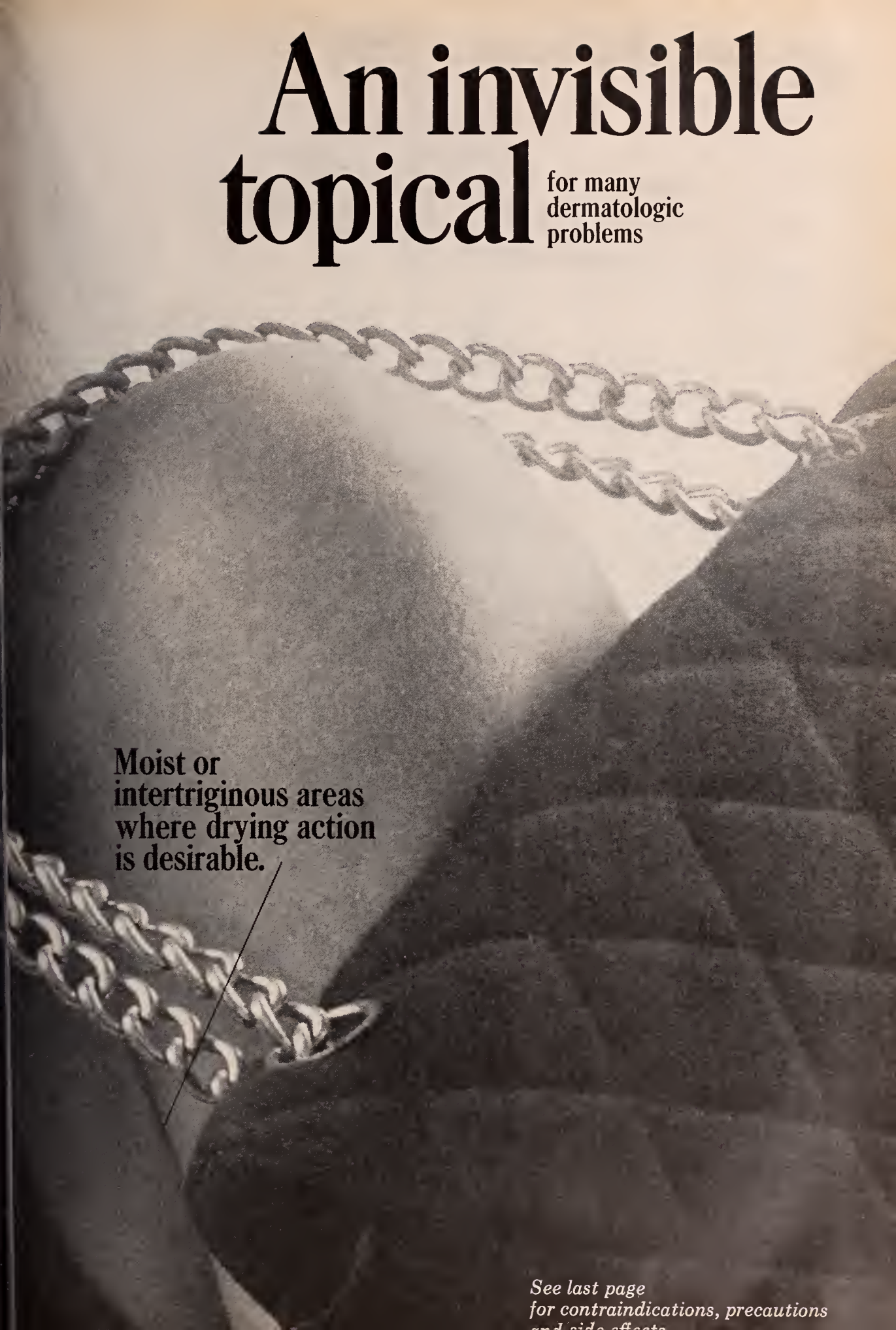
CONTRAINDICATIONS: Sensitivity to Cantil® (mepenzolate bromide), glaucoma, G.I. or G.U. obstruction, toxic megacolon. **WARNINGS:** Possibility of adverse reactions in advanced severe ulcerative colitis and atypical agitated reactions to phenobarbital in the elderly (Cantil with Phenobarbital). **PRECAUTIONS:** Cantil is of adjunctive use only; treatment of the underlying condition is indicated, be it organic or functional. Observe caution in conditions known to be incompatible with atropine-like drugs, e.g., open-angle glaucoma or prostatic hypertrophy. **ADVERSE EFFECTS:** Dry mouth; blurred vision; constipation; nausea; vomiting; bloating; dizziness; urinary retention. All are anticholinergic effects and usually tolerable. Habituation and idiosyncratic reactions to phenobarbital (Cantil with Phenobarbital) are possible, as is generalized rash. **DOSAGE:** One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required. **HOW SUPPLIED:** CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

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Hairy sites where creams and ointments do not spread or penetrate readily.
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for many dermatologic problems



See last page for contraindications, precautions and side effects

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In many areas of the body, hair gets in the way of treating the underlying dermatitis. The propylene glycol vehicle of Synalar Solution permits penetration and dispersion at sites where creams and ointments do not readily penetrate. May be applied without matting of hair.

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Propylene glycol is strongly hygroscopic and is especially useful where sweat retention is a problem. Its low surface tension permits easy spreadability in difficult-to-treat body areas. A number of studies have also shown that propylene glycol has inherent antimicrobial activity.



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Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components.

Precautions: In some patients with dry lesions, the solution may increase dryness, scaling, or itching. Application to denuded or fissured areas, such as genital or perianal sites, may produce a burning or stinging sensation. If this persists and dermatitis does not improve, discontinue medication. Although propylene glycol has antiseptic activity, there should be careful initial evaluation and follow-up of infected sites. Incomplete response or exacerbation of lesions may be due to true infection, which requires susceptibility testing and appropriate therapy. On the other hand, saprophytic or low grade infections may clear spontaneously under the influence of Synalar Solution alone. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

Side Effects: Side effects are not encountered ordinarily with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions.

Availability: Synalar (fluocinolone acetonide) Solution 0.01% in a propylene glycol vehicle with citric acid as preservative. 20 and 60 cc. plastic squeeze bottles. *Also available:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

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A large (10″ x 10″) booklet which features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.



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Please see Brief Summary on next page.

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Brief Summary

DESOXYN® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

DESBUTAL® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

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Vitamin B_1	7.5 mg
Vitamin B_2	7.5 mg
Vitamin B_6	7.5 mg
Vitamin B_{12}	50 mcgm
Vitamin C	200 mg
Niacinamide	30 mg
Folic Acid	0.05 mg
Pantothenic Acid	15 mg

Bottles of 60

*anticostive, *adj.* (*anti* opposed to + *costive* causing constipation.) Against constipation. (Now isn't that a good idea in an iron-containing hematinic? We'll send you samples if you'll send a request on your Rx blank, addressed to Department 150.)

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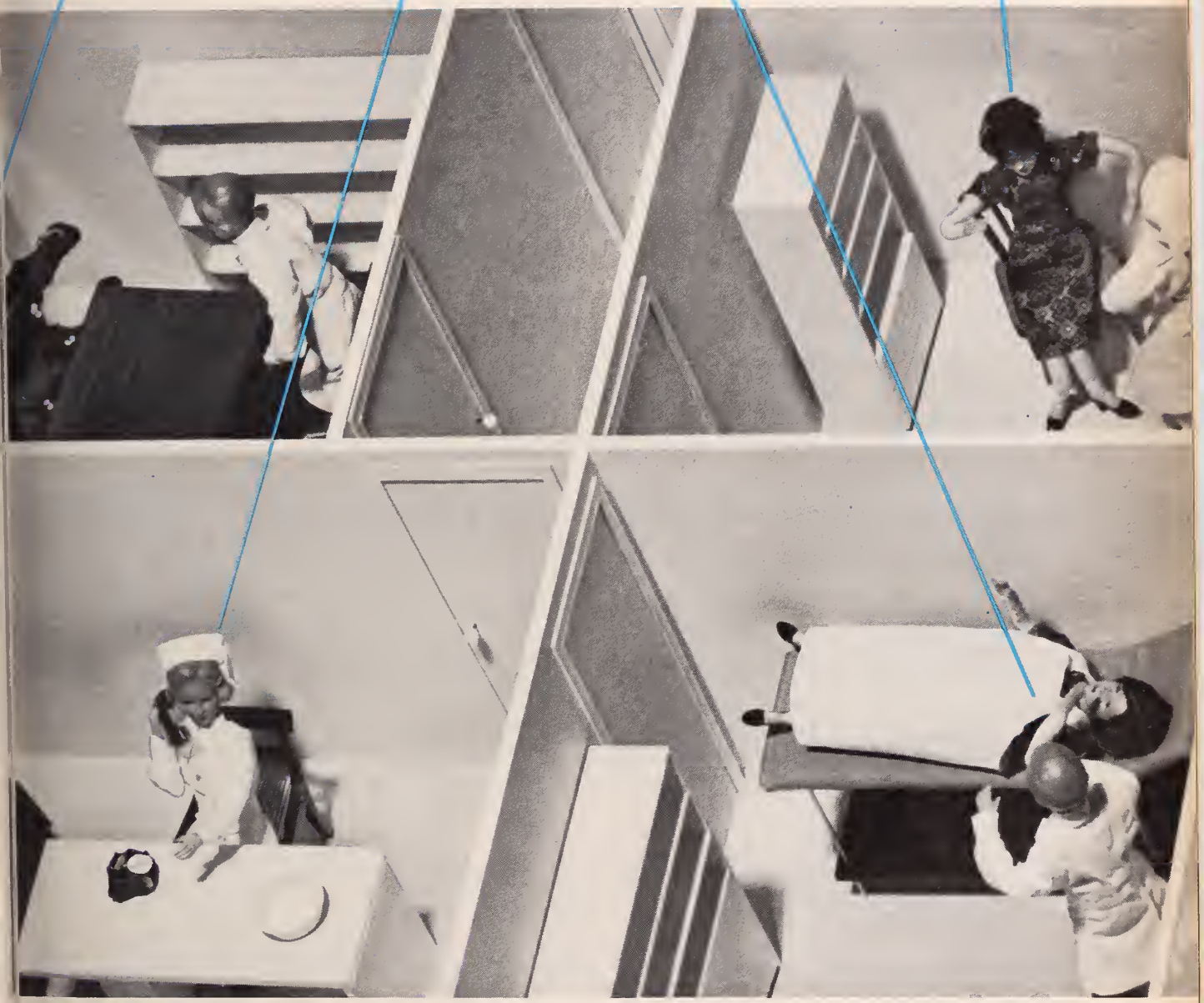
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She asks for your help, but just can't seem to follow through on your advice.

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ontraindications: Severely depressed or omatose states from any cause, and in ssociation with or following MAO inhibi- rs; severe hypertensive or hypotensive eart disease.

recautions: Hypersensitivity reactions .g., leukopenia, agranulocytosis) and nvulsive seizures are infrequent. Pig- entary retinopathy has been observed here doses in excess of those recom- ended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

for moderate to severe anxiety

Mellaril®

(thioridazine)

25 mg. t.i.d.

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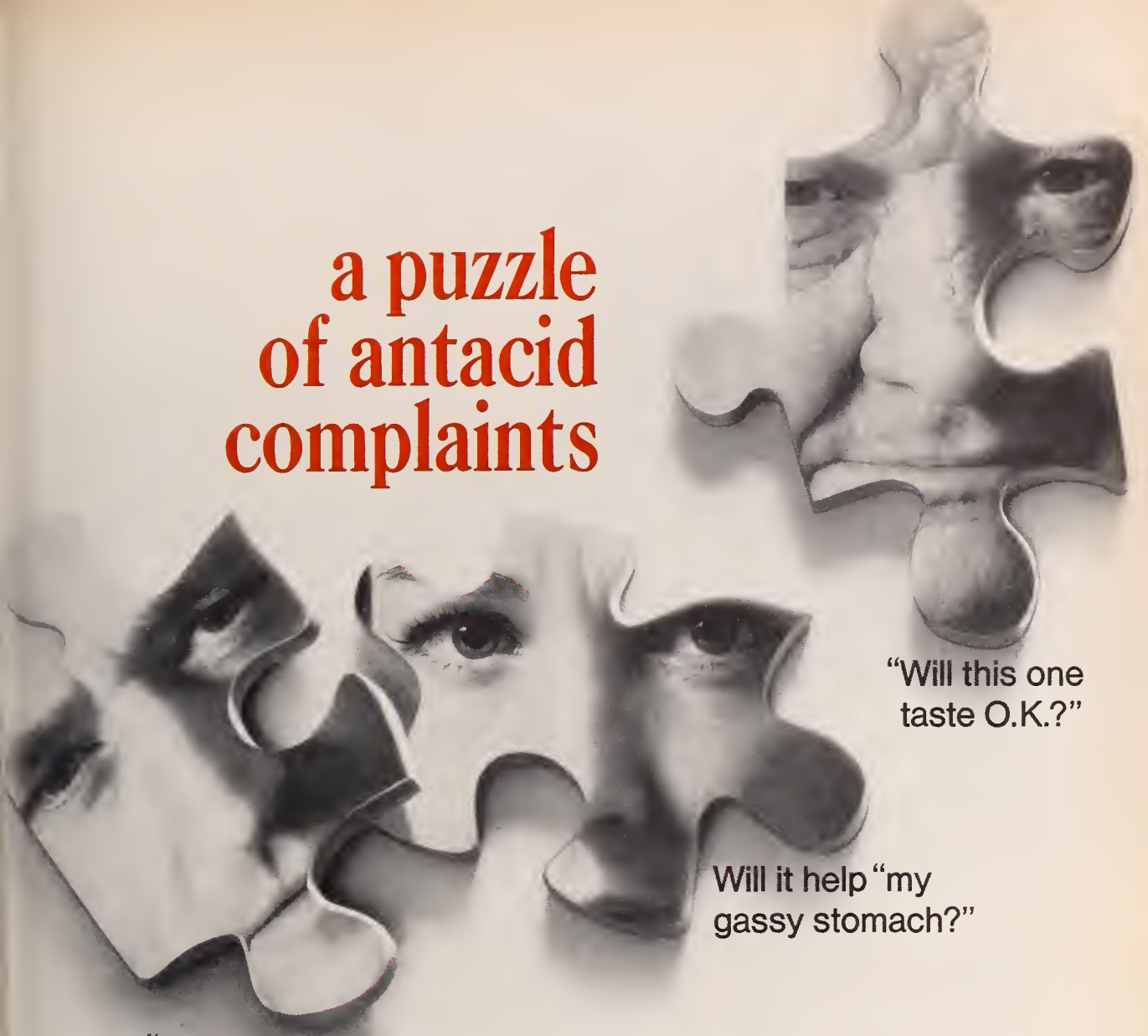
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Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A

a puzzle of antacid complaints



Mylanta®

aluminum and magnesium hydroxide *plus* simethicone

a solution to peptic ulcer distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

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in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I. E., Personal communication.

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ATLAS CHEMICAL INDUSTRIES, INC.



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

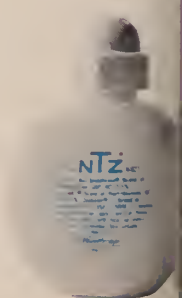
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NTz is more than a simple vasoconstrictor. It contains

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Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.

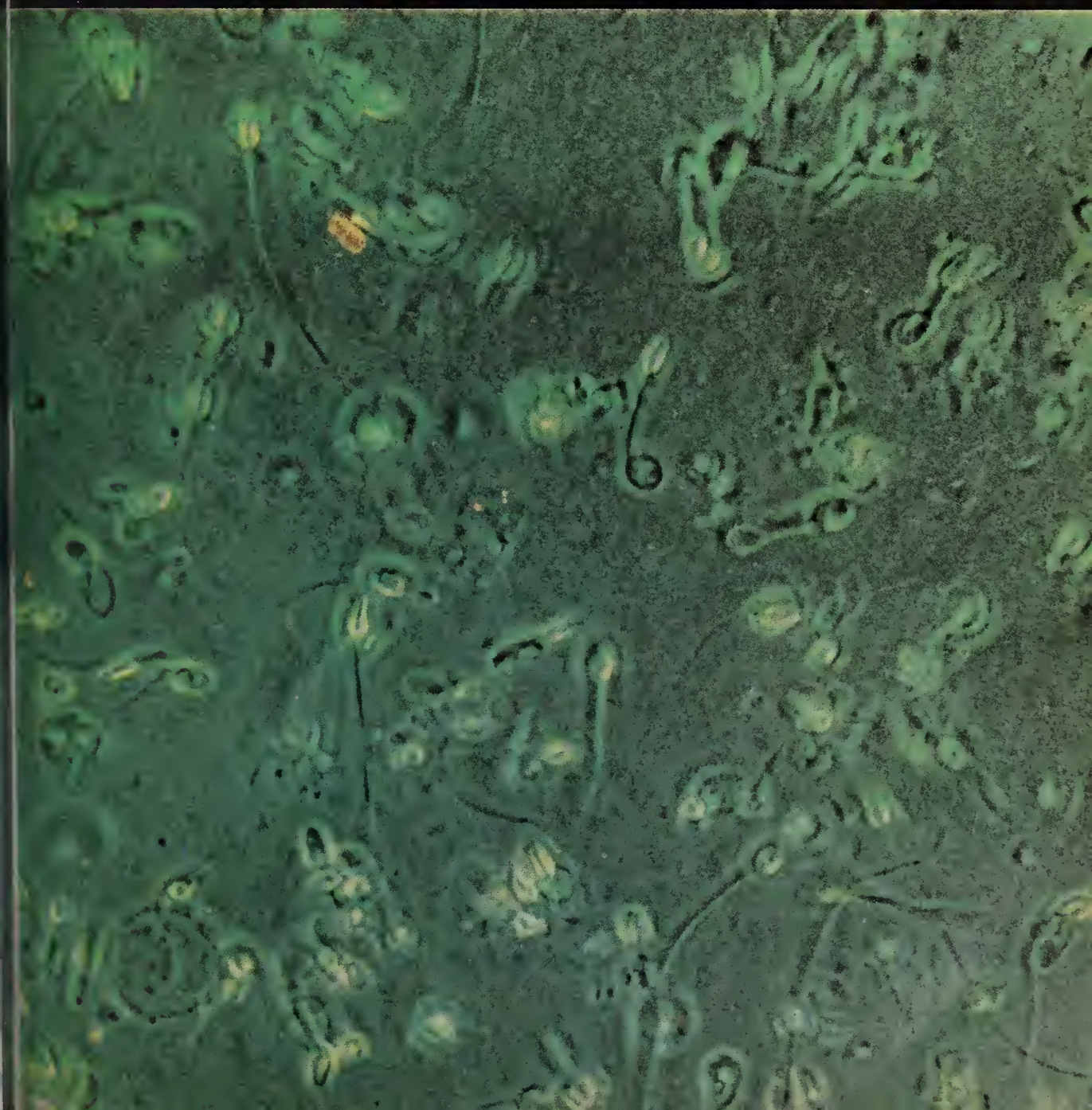


Winthrop Laboratories, New York, N.Y. 10016 Winthrop

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c mestranol 0.05mg.)

Turn page for contraindications, precautions and side effe



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. 11. Because of the effects of estrogens on epiphyseal closure, NORINYL-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with NORINYL-1 may mask the onset of the climacteric. 13. The pathologist should be advised of NORINYL-1 therapy when relevant specimens are submitted.

Side effects observed in patients receiving oral contraceptives: The following adverse reactions have been observed in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weig (increase or decrease), changes in cervical erosion and cervical secretio suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression.

Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation post-treatment, premenstrual-like syndrome, change in libido, changes in appetite, cystiti like syndrome, headache, nervousne dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nod sum, hemorrhagic eruption, itching

The following occurrences have bee observed in users of oral contraceptives (a cause and effect relationship has been neither established nor di proved): thrombophlebitis, pulmona embolism, neuro-ocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, Factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine an decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

SYNTEX

LABORATORIES INC PALO ALTO CALIF

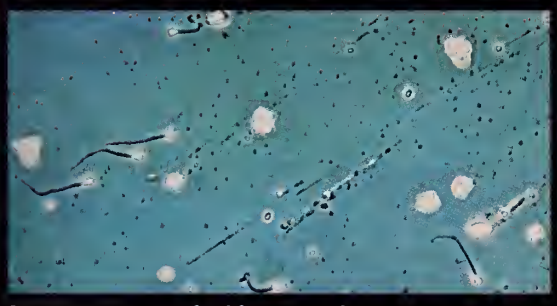
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

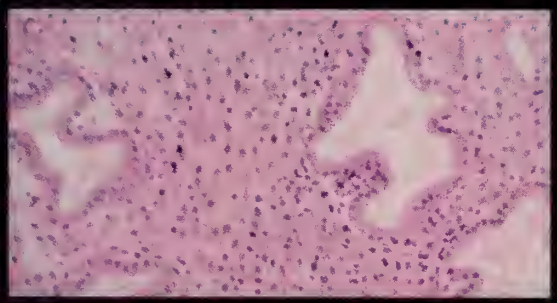
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.

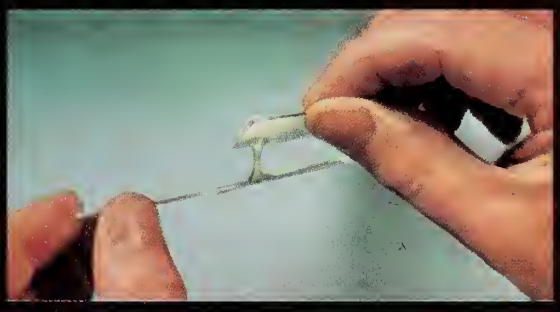


Spermatozoa appear healthy, active, freemoving.

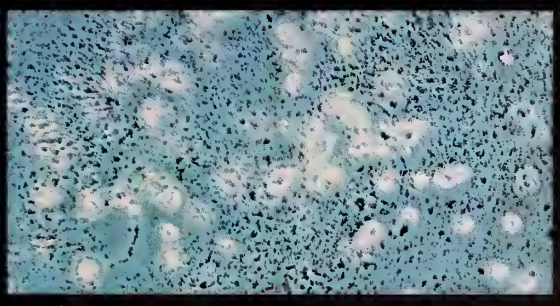


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

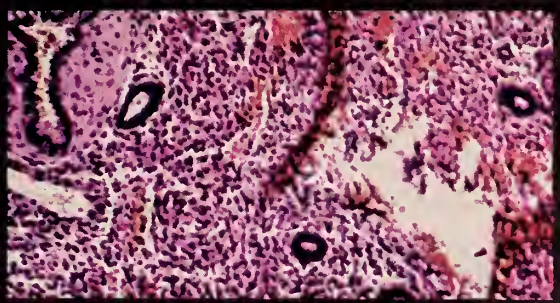
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



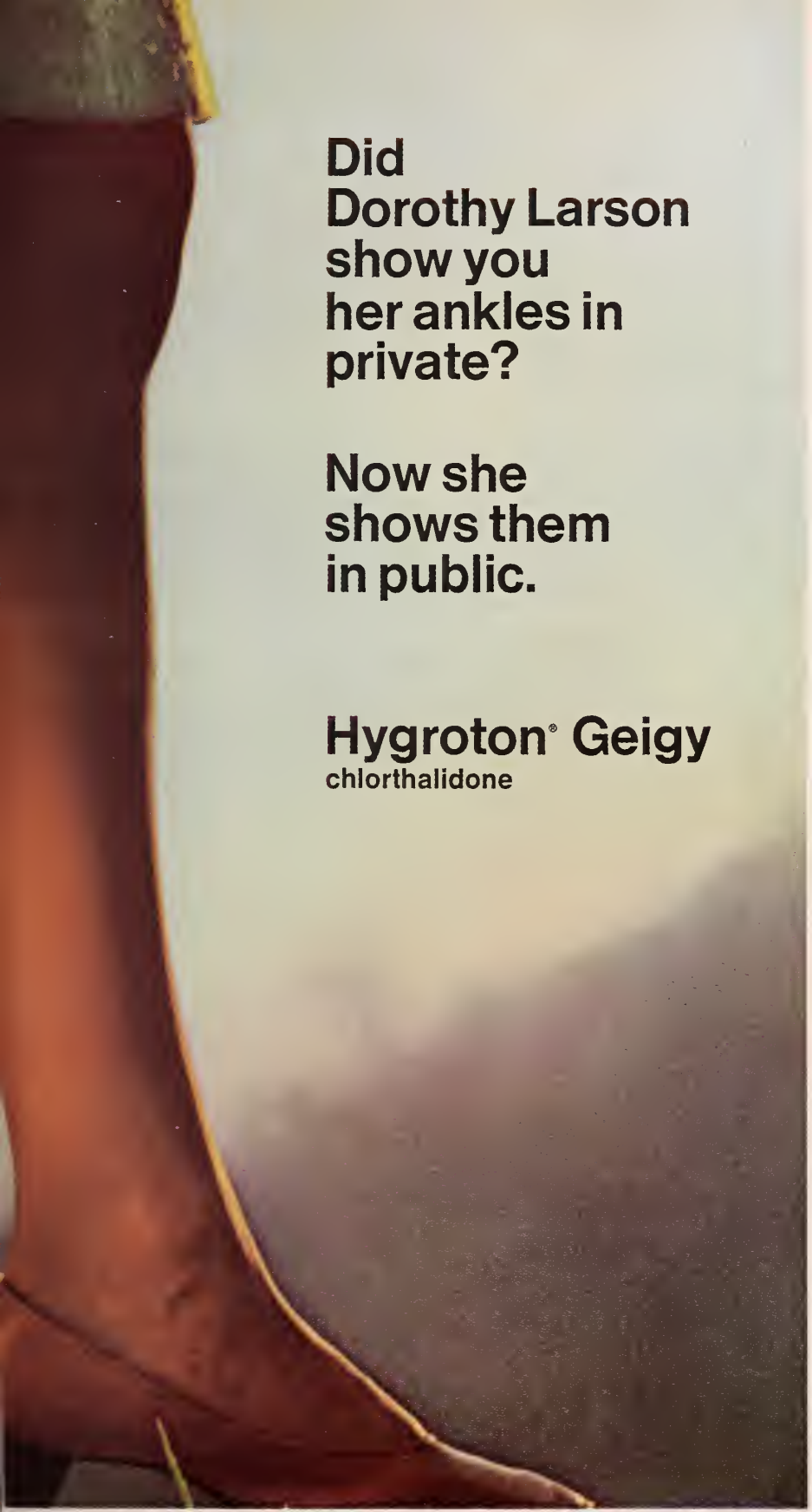
Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1
(norethindrone 1mg ē mestranol 0.05mg) tablets

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost



Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowef lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Be
cause of the possibility of prog
sion of renal damage, periodic
determination of the BUN is ind
cated. Discontinue if the BUN r
or liver dysfunction is aggravat
Hepatic coma may be precipita
Electrolyte imbalance, sodium
or potassium depletion may oc
If potassium depletion should
cur during therapy, Hygroton sh
be discontinued and potassium
supplements given, provided th



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Your office examination confirmed Mrs. Larson's ankle edema.

You prescribed Hygroton—to get rid of the edema.

And you found that Hygroton is not only effective; it frequently costs less than other equivalent therapy.

A nice way to treat the Mrs. Larsons in your practice.

Hygroton therapy may mean troublesome side effects for some patients. A summary of the prescribing information is shown below.

t does not have marked oli-

pecial care in cirrhosis or ischemic heart disease and ents receiving corticoste- ACTH, or digitalis. Salt re- on is not recommended.
e Reactions: Nausea, gastric on, vomiting, anorexia, con- on and cramping, dizziness, ess, restlessness, hyperglyc- hyperuricemia, headache, cramps, orthostatic hypo- tension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.
Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.
Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.
(B)R46-230-D
For full details, please see the complete prescribing information.

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Division of
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HY-5576R

Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.



Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.
Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

DOW PITMAN-MOORE DIVISION OF THE DOW CHEMICAL COMPANY, INDIANAPOLIS



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He's the one who needs your professional help.

You can help the faddist realize there's really no fast way. And, that a healthy loss requires changing ways as well as weight. Explain the benefits of a planned program of diet, exercise, proper rest and will power. Work out a sound program to keep him physically fit.

Project Weight Watch can help, too. We have available free materials and suggested diets. Scientific diets based on the 4 food groups—meat, breads and cereals, fruits and vegetables and dairy foods. These are diets you'd write yourself if you had time. Take a minute and send for them.

PROJECT WEIGHT WATCH

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Help the Needy!



A patient of advancing years may appear to "have everything," but may well be in need—*medically*. You know the symptoms. She's tired most of the time. Though there's nothing wrong with her organically, she suffers from general malaise. Lassitude has become her way of life . . . vague aches and pains her major concern.

Such a patient has entered the "Mediatric Age"—that stage of her life in which she's an ideal candidate for MEDIATRIC. This preparation provides the anabolic benefits of gonadal steroids, plus a gentle mood uplift and the nutritional support she's apt to need. MEDIATRIC is intended to help keep her more alert and active, and relieve general malaise . . . to help restore that sense of physical and emotional well-being that the elderly *deserve* to enjoy.

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens-equine), the orally active, natural estrogen so widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain anabolic balance to forestall premature degenerative changes related to estrogen deficiency. MEDIATRIC also supplies a small amount of *methamphetamine HCl* to provide a gentle mood uplift, and nutritional supplements specially selected to meet the needs of the aging.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.
WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.
SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.
SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.
In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).
In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.
SUPPLIED: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.
No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.
No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon.

	Each MEDIATRIC Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsiccated	30.0 mg.	—
Ascorbic acid	100.0 mg.	—

(Contains 15% alcohol†)
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Steroid-nutritional compound

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Greetings

To the Members of
The Medical Society of
New Jersey

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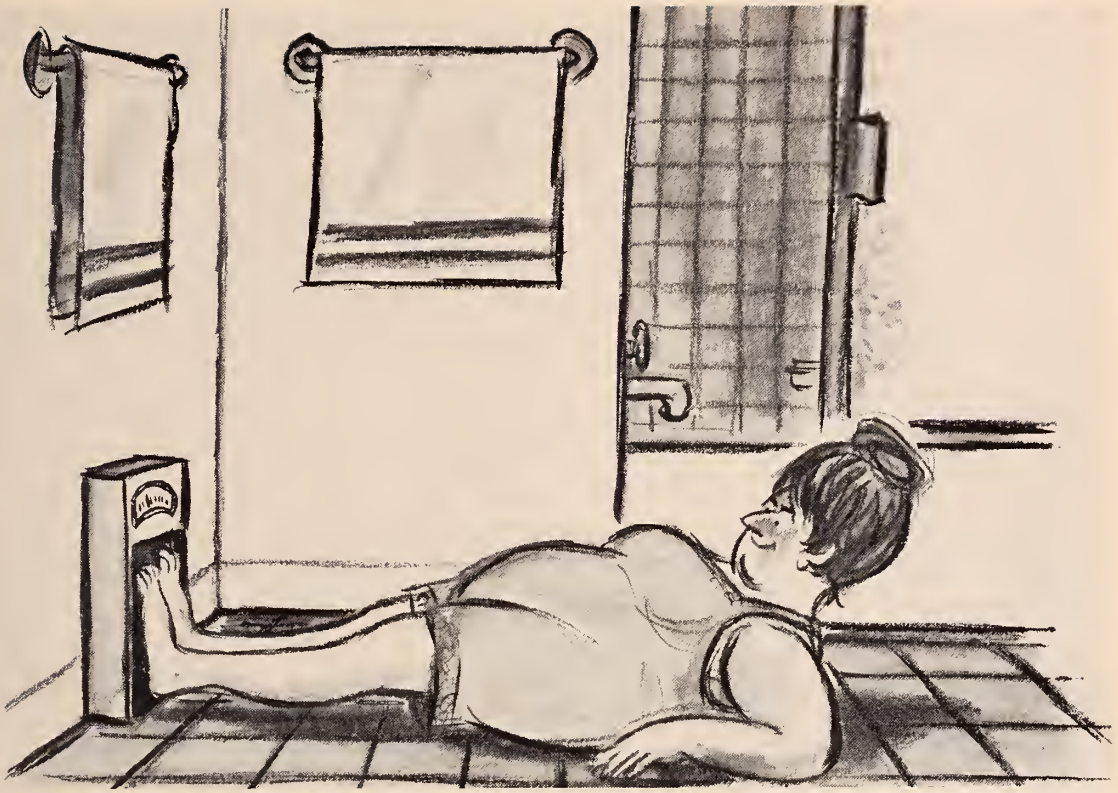
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A. L. VAN HORN, M.D., Medical Director
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Your cartoon suggestions are invited for this series.

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Each OBETROL-10 tablet contains: Methamphetamine Saccharate; 2.5 mg. Methamphetamine Hydrochloride; 2.5 mg. Amphetamine Sulfate; 2.5 mg. Dextro-amphetamine Sulfate; 2.5 mg. (OBETROL-20 tablets contain twice this potency) Pat. #2748052.

Tip the scale in her favor

This combination of amphetamines may be useful as an adjunct in the management of certain forms of obesity where an appetite depressant is indicated.

Contraindications: Hypertension, advanced arteriosclerosis, coronary artery disease, cardiac arrhythmias, peripheral vascular disease, states of undue restlessness, anxiety, excitement, agitated depression, hyperthyroidism, idiosyncrasy to amphetamine, concomitant administration of a monoamine oxidase inhibitor. **Precautions:** Use with caution in individuals with anorexia, insomnia, vasomotor instability, asthenia, psychopathic personality, a history of homicidal or suicidal tendencies, and individuals who are known to be hyperractive to sympathomimetic agents, or emotionally unstable individuals who are known to be susceptible to drug abuse. Certain monoamine oxidase inhibitors may potentiate the action of Obetrol. **Side Effects:** The most common side effects attended with the use of amphetamines include nervousness, excitability, euphoria, insomnia, dryness of mouth, nausea, vertigo, constipation, and headache.

Dosage and Administration: Initial adult dose is one-half to one 'Obetrol-10' tablet daily, preferably one-half to one hour before meals. This may be gradually increased to one 'Obetrol-10' or 'Obetrol-20' tablet one to three times daily as indicated. **Supplied:** Tablets scored, in bottles of 100, 500, and 1000.

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DR. _____

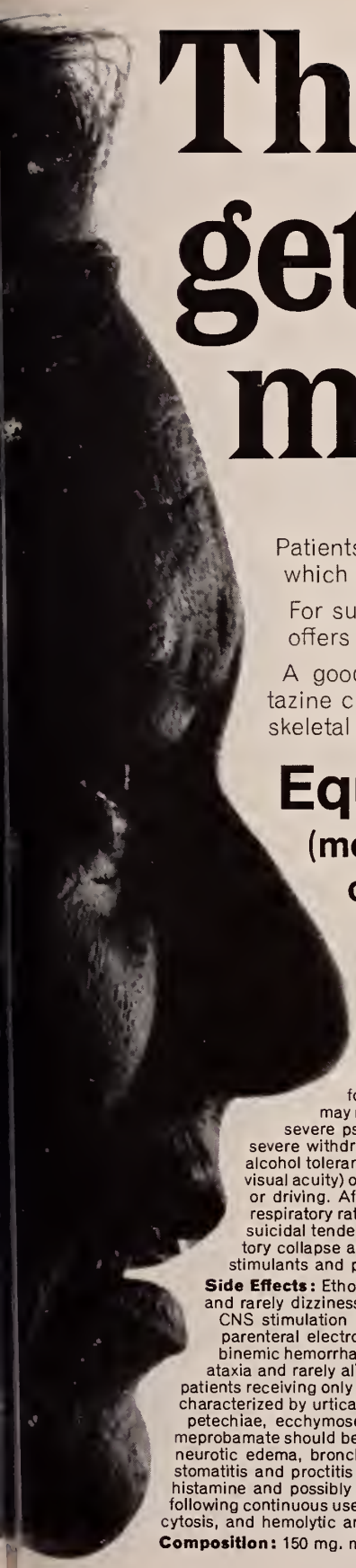
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This pain is getting on my nerves.

Patients in pain often experience concomitant anxiety and tension, which may add to the burden of pain.

For such patients, you may want to prescribe a preparation that offers more than simple analgesia.

A good choice is often EQUAGESIC® (meprobamate and ethoheptazine citrate with aspirin). It helps relieve pain. And anxiety. And skeletal muscle spasm as related to pain or anxiety and tension.

Equagesic® TABLETS

(meprobamate and ethoheptazine citrate with aspirin)

Wyeth®

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.



Now...twice as much as before in each teaspoon

400,000 units of potassium penicillin V per teaspoonful

New...V-Cillin K®, Pediatric, 250 mg.

Potassium Phenoxymethyl Penicillin

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EDITORIALS

Is The Medical Society Representative?

It is sometimes whispered in the cloak rooms of hospitals and in lobbies of medical meetings, that the medical society is not truly representative of the doctors of the community. The allegation takes many forms. When a society — whether the AMA or a state society, a specialty group, a hospital staff, or a county medical unit — issues a resolution, there are those who say that it does not speak for the profession generally. It is said that a few leaders make all the decisions and force the rank and file to accept them under threat of some dark and mystic penalty. Or that a cabal representing one hospital, one geographic area, or one school of thought, has somehow seized the society's machinery.

It is true that a member can effectively disfranchise himself by never going to meetings, by tossing all mail ballots into the waste basket, and by failing to perform committee service when asked. And if 60 per cent of the members evade all society contacts, then, perforce, the remaining minority must make decisions and take actions. However, under those circumstances, it seems scarcely fair for the coatholder to tell the fighter how to fight.

There is indeed, a magic pass-word to medical society participation. No, it is not a Greek letter fraternity phrase, nor is it a slogan reflecting the old school tie. It is not a secret word known only to the initiate. It is a simple four letter Anglo-Saxon word: "work." Utter it with sincerity to one of the officers of the society. The key phrase is: "How may I help?" Almost any member who drops a hint that he is willing to serve on a committee, who attends meetings regularly, who stands on his own two feet and says so when he disagrees with a proposal, almost any such member will be given a chance to participate. Maybe, in fact, one medical association or another does not sensitively reflect the opinions of the general membership. It could be. But whose fault is *that*? If the "unrepresented" member never voiced his opinion, never went to a business meeting, never offered to serve on a committee, who is to blame for his failure to make an impression?

You'll be getting a notice of a county medical society meeting soon. There will be a State Society meeting in Atlantic City next month. Perhaps you belong to a specialty association or a hospital staff society. No one is diverting your mail or standing guard at the door to keep you out.

Welcome, thrice welcome.

Family Medicine For Medical Students

Medical education—like all education—comes in for a lot of brickbats these days. One of the current criticisms is that the medical student never gets to see a patient in his normal milieu, but only in the artificial environment of the hospital or clinic. This leads the student to isolate the illness from its social background. It makes him forget that patients have families. It leads to such absurdities as recommending that an arthritic and widowed scrub woman treat her arthritis by basking for the winter in Florida's sun and sand. And it leads away from "family practice" even though one of the avowed aims of the medical school is to train family doctors, rather than specialists.

It is heartening to see that at least one medical school is doing something about it. Vanderbilt University's School of Medicine has for some time operated a program in which medical students make regular visits to the homes of patients. They encourage the student to act as a family health advisor to a group of families. They learn the ministry of

listening, the curious healing force that flows out of the relationship when the doctor will listen patiently and sympathetically. They do not see disease tied up into neat packages with all the "extraneous" or nonmedical aspects trimmed off. Instead they see disease as part of a total personality and see that total person as part of a family, of a neighborhood, of a community, which is as it should be.

Every one talks about the "social" aspect of disease, about disease being a social phenomenon, as well as a biological one. Every one talks about the importance of persuading young physicians to become true family doctors. But no one *does* anything about this. Well, almost no one. In Nashville, they *do* do something about it.

Cancer Phobia And The Cigaret Smoker

On page 176 of this issue, we publish a letter from Dr. Albert Hulett. Of course the "prevention of one or two cancers," as he so casually puts it, *is* a pretty sound justification for public education. However, he does raise an interesting issue. Does the aggressive campaign against smoking cigarets really pay off in terms of getting some people unhooked from nicotine? And, does the very vigor of the propoganda precipitate hypochrondriasis and anxiety in patients? While tuberculosis hospitals have, generally, stopped selling cigarets in the coffee shops or through slot machines, most psychiatric hospitals continue to make them available. And the reasoning is pretty much along the lines that Dr. Hulett suggests. Dealing with people who, presumably, are already suggestible and anxious, it has seemed to those in authority that they cannot deprive their patients of this weed which, in some cases, appears to "calm their nerves" (to use a layman's term) or provide a socially acceptable, if dangerous, outlet to their pressure of action and movement.

Dr. Hulett himself has stopped smoking and thus joined about 50,000 other M.D.'s in the United States who have given up cigarets. (These figure come from a release prepared by the District of Columbia Medical Society). The rationalizations for continued smoking have already been discussed* and most of us know what they are. Dr. Hulett suggests that smokers, in spite of the evidence, "have continued the habit and reveal a lack of motivation or will-power to terminate it." He then argues that persons with this kind of defect in motivation or will must be already apprehensive and we shouldn't add to their anxiety by scare literature. This point has been made with reference to the scare campaigns against alcohol, veneral disease, LSD, and heroin. Experience seems to indicate that most people are not influenced by such campaigns. The cigaret smoking habit is, after all, unreasonable to begin with, so one can hardly expect it to be influenced by an appeal to reason. However, it is possible that an appeal to *emotions* as distinct from *reason* might work.

Dr. Hulett raises another, thought-provoking point. Shouldn't the editors of *Reader's Digest* (where the article appeared in the January 1968 issue) have consulted a psychiatrist about the possibly adverse emotional effects of this kind of propaganda? And, for that matter, he asks, shouldn't the USPHS have consulted with one of its own psychiatrists, too? The Public Health Service has given this article its sponsorship, and thus placed itself on the horns of a peculiar dilemma. On the one hand to stir up anxiety and hypochondriasis in thousands? On the other hand, to prevent cancer in, perhaps hundreds.

Physicians certainly have a duty here not to encourage cigaret smoking by their own indulgence; and hospitals ought to keep cigarets out of their vending machines, canteens, and coffee shops. This can be done silently without preaching. But we must not give justification by telling the patient, in effect, "do as I say, not as I do."

* Davidson, Henry A.: Rationalizations for Continued Smoking. *New York State Journal of Medicine*, 64:2994 (December 15, 1964)

202nd ANNUAL MEETING

The Medical Society of New Jersey

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Louis K. Collins, M.D.
President

Jerome G. Kaufman, M.D.
Chairman, Annual Meeting Committee

Milton Ackerman, M.D.
Chairman, Scientific Exhibits

James A. Rogers, M.D.
Chairman, Scientific Program

Marion R. Walton
Convention Manager

May 18-22, 1968
Chalfonte-Haddon Hall
Atlantic City

1968 Annual Meeting

DAILY SCHEDULE

Saturday through Wednesday
May 18 to 22, 1968

Chalfonte-Haddon Hall
Atlantic City

Friday / May 17, 1968

4:00 p.m.—Board of Trustees

Saturday / May 18, 1968

10:00 a.m.—Registration Opens
1:00 p.m.—Golden Merit Award Ceremony
followed by
Reception for Award Recipients and Their Families
3:00 p.m.—House of Delegates and President's Farewell Address
followed by
Open Discussion on Medical-Surgical Plan
5:30 p.m.—Reception, Essex County Medical Society
(by invitation only)
4:30 p.m.—Nominating Committee
7:00 p.m.—Officers' Dinner
(by invitation only)

Sunday / May 19, 1968

9:00 a.m.—Registration Opens
9:30 a.m.—Special Scientific Session on Religion and Medicine
Presented by The Academy of Medicine of New Jersey
10:00 a.m.—Coffee-Meeting with Reference Committee Chairmen
10:45 a.m.—Reference Committees
12:00 noon—Exhibits Open
1:00 p.m.—Special Scientific Session on Suicide
Presented by the New Jersey State Department of Institutions and Agencies
2:00 p.m.—Motion Picture Theatre
3:15 p.m.—House of Delegates (election)
4:00 p.m.—General Session
Address of Incoming President
Address of AMA President-Elect
(Open to all registered members and invited guests)
6:00 p.m.—Inaugural Reception Honoring President-Elect Kustrup
(All members, official guests, and their wives, and Auxiliary members are cordially invited to attend—admission by badge)
8:00 p.m.—Inaugural Dinner
(by invitation only)

Monday / May 20, 1968

7:30 a.m.—Breakfast, JEMPAC
9:00 a.m.—Registration and Exhibits Open
9:00 a.m.—Scientific Session on Obstetrics and Gynecology, Urology
9:15 a.m.—Scientific Session on Orthopedic Surgery, in cooperation with the New Jersey Orthopaedic Society
9:30 a.m.—Scientific Sessions:
Allergy, Otolaryngology, Pediatrics
Anesthesiology, Gastroenterology and Proctology, General Practice
Clinical Pathology, Metabolism
10:00 a.m.—Motion Picture Theatre
12:15 p.m.—Luncheon, New Jersey Orthopaedic Society
2:00 p.m.—Scientific Sessions:
Chest Diseases
Psychiatry and Neurology
Radiology, Surgery
Rheumatism
2:00 p.m.—Motion Picture Theatre
7:00 p.m.—Annual Dinner-Dance
(All members, official guests and their wives, and Auxiliary members are cordially invited to attend)

Tuesday / May 21, 1968

9:00 a.m.—Registration and Exhibits Open
9:30 a.m.—House of Delegates
10:00 a.m.—Motion Picture Theatre
2:00 p.m.—Scientific Sessions:
Cardiovascular Diseases, Medicine (in cooperation with the Bergen County Heart Association)
Dermatology (in cooperation with the Industrial Medical Association of New Jersey)
Ophthalmology
Plastic and Reconstructive Surgery, (in cooperation with the New Jersey Society of Plastic Surgeons)
2:00 p.m.—Motion Picture Theatre
5:30 p.m.—Jefferson Medical College Alumni Open House
7:00 p.m.—Reception—Buffet Dinner for Technical Exhibitors
(by invitation only)

Wednesday / May 22, 1968

9:00 a.m.—Registration and Exhibits Open
9:00 a.m.—Board of Trustees
10:30 a.m.—Clinical Pathologic Conference
Two cases will be presented
12:00 noon—Registration and Exhibits Close

1968 Annual Meeting

GOLDEN MERIT AWARDS

Saturday, May 18th 1:00 p.m.

Presiding
Louis K. Collins, M.D., President

Master of Ceremonies
Harry F. Suter, M.D., Chairman, Council on Public Relations

Marshals
Presidents of Component Societies whose members are receiving awards

The Golden Merit Award, established in 1957, is conferred upon every member of The Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years.

Recipients For 1968

County	Member
Atlantic	James H. Mason, III, M.D. Daniel C. Reyner, M.D. Sidney Rosenblatt, M.D. George C. Schwarzkopf, M.D.
Bergen	William J. Greenfield, M.D.
Burlington	Joseph M. Kuder, M.D. S. Emlen Stokes, M.D.
Camden	William A. H. Scheffler, M.D. Benjamin M. Wroblewski, M.D.
Cumberland	Horace J. Ettinger, M.D.
Essex	Nicholas V. Del Deo, M.D. Haynes H. Fellows, M.D. Toufick Nicola, M.D. John N. Pannullo, M.D. Abraham L. Reich, M.D. Ralph H. Salsberg, M.D. Samuel Schulsinger, M.D. Paul Slavin, M.D. Elmer W. Smalzried, M.D. Leo M. Strauss, M.D. Mykola Terlecky, M.D. John Wagner, M.D. Irving Willner, M.D.
Hudson	Samuel Selinger, M.D. William L. Yeaton, M.D.
Mercer	Johannes F. Pessel, M.D. Ernest F. Purcell, M.D. Paul B. Reisinger, M.D. Jeems B. Spradley, M.D. Stephen Vaczi, M.D.
Middlesex	Edward Hurtado, M.D. William London, M.D.
Monmouth	Robert H. Stockfisch, M.D.
Passaic	J. Vernon Hughes, M.D. Abraham Kovin, M.D. Sandor A. Levinsohn, M.D. Dominick Marini, M.D. Joseph F. A. RuBacky, M.D.
Union	William B. Fort, M.D. Robert S. Milligan, M.D. Stephen A. Steele, M.D.

Reception for Recipients and Families Following Ceremony

1968 Annual Meeting

REFERENCE COMMITTEES

Sunday, 10:45 a.m. May 19, 1968

Reference Committee on Constitution and Bylaws

Reports of the:
- Committee on Revision of Constitution and Bylaws
- Amendments to Constitution
- Amendments to Bylaws

Reference Committee "A"

Reports of the:
- President
- Board of Trustees
- Secretary
- Judicial Council
- Executive Director
- Committee on Credentials

Reference Committee "B"

Reports of the:
- Treasurer
- Committee on Finance and Budget
- Committee on Publication
- Committee on Medical Student Loan Fund

Reference Committee "C"

Reports of the:
- Medical-Surgical Plan of New Jersey

Reference Committee "D"

Reports of the:
- Committee on Medical Defense and Insurance
- Committee on Medical Education
- Committee on Medicine and Religion
- Committee on Retirement Plan for Physicians

Reference Committee "E"

Reports of the:
- Council on Legislation
- Council on Public Relations

Reference Committee "F"

Reports of the:
- Council on Medical Services, and its Special Committee on:
  - Occupational Health, Rehabilitation, and Workmen's Compensation

Reference Committee "G"

Reports of the:
- Council on Public Health, and its Special Committees on:
  - Air Pollution Control
  - Cancer Control
  - Child Health
  - Conservation of Vision
  - Maternal and Infant Welfare
- Council on Mental Health, and its Special Committees on:
  - Alcoholism
  - Drug Addiction
  - Emotional Disorders of Childhood and Adolescence
  - Mental Retardation
  - Seizures

Reference Committee "H"

Reports of the:
- Committee on Annual Meeting
- Committee on Honorary Membership
- Committee on Emergency Medical Care
- Committee on Traffic Safety
- Advisory Committee to the Woman's Auxiliary
- Nominations for Emeritus Membership

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

1968 Annual Meeting

HOUSE OF DELEGATES

Saturday, 3:00 p.m. — May 18, 1968
Sunday, 3:15 p.m. — May 19, 1968
Tuesday, 9:30 a.m. — May 21, 1968

President—Louis K. Collins, M.D., Glassboro
Secretary—Marcus H. Greifinger, M.D., Newark
Speaker—Jesse McCall, M.D., Newton
Parliamentarian—Robert M. Backes, Trenton

Sessions

Saturday, May 18—3:00 p.m.

First Session

Invocation

Robert B. Howe, Minister, The First Methodist Church, Glassboro

Call to Order by the Speaker
Jesse McCall, M.D.

Organization of the House

Transactions of the 1967 House of Delegates

Introduction of Guests and Delegates from Other States

Annual and Supplemental Reports

Proposed Amendments to the Constitution and Bylaws

Resolutions

New Business

Announcements

President's Farewell Address

Sunday, May 19—3:15 p.m.

Second Session

Report of Nominating Committee

Election

(At the conclusion of this meeting of the House of Delegates a General Session will convene.)

Tuesday, May 21—9:30 a.m.

Third Session

Reports of Reference Committees

Unfinished Business

Adjournment

(Luncheon Recess—1:00-1:30 p.m.)

OFFICES TO BE FILLED BY ELECTION — 1968 ANNUAL MEETING

Office	Term	From	To	Incumbent and County
President-Elect	1 year	May 1968	May 1969	John F. Kustrup Mercer
1st Vice-President	1 year	May 1968	May 1969	Nicholas A. Bertha Morris
2nd Vice-President	1 year	May 1968	May 1969	Emanuel M. Satulsky Union
Secretary	1 year	May 1968	May 1969	Marcus H. Greifinger Essex
Treasurer	1 year	May 1968	May 1969	Samuel J. Lloyd Mercer
Trustees:				
1st District	3 years	May 1968	May 1971	Jerome G. Kaufman Essex
2nd District	3 years	May 1968	May 1971	Thomas C. DeCecio Bergen
5th District	3 years	May 1968	May 1971	Nicholas E. Marchione Cumberland
Judicial Councilors:				
2nd District	3 years	May 1968	May 1971	John L. Olpp Bergen

Office	Term	From To	Incumbent and County
5th District	3 years	May 1968-May 1971	John S. Madara Salem
AMA Delegates	2 years	Jan. 1969-Dec. 1970	C. Byron Blaisdell Monmouth
	2 years	Jan. 1969-Dec. 1970	Marcus H. Greifinger Essex
	2 years	Jan. 1969-Dec. 1970	Frank J. Hughes Camden
	2 years	Jan. 1969-Dec. 1970	Luke A. Mulligan Bergen
AMA Alternate Delegates:	2 years	Jan. 1969-Dec. 1970	John J. Bedrick Hudson
	2 years	Jan. 1969-Dec. 1970	Matthew E. Boylan Hudson
	2 years	Jan. 1969-Dec. 1970	Jerome G. Kaufman Essex
	2 years	Jan. 1969-Dec. 1970	John F. Kustrup Mercer
Delegates and Alternate Delegates to Other States:			
New York:			
Delegate	1 year	1969 Annual Meeting	Joseph P. Donnelly Hudson
Alternate	1 year	1969 Annual Meeting	John W. Holland Atlantic
Connecticut:			
Delegate	1 year	1969 Annual Meeting	Lloyd A. Hamilton Hunterdon
Alternate	1 year	1969 Annual Meeting	Frank W. Konzelmann Atlantic
Administrative Councils:			
Legislation:			
1st District	3 years	May 1968-May 1971	S. William Kalb Essex
4th District	3 years	May 1968-May 1971	Meyer L. Abrams Burlington
Medical Services:			
1st District	3 years	May 1968-May 1971	Francis J. Benz Morris
4th District	3 years	May 1968-May 1971	Frederick W. Durham Camden
Mental Health:			
1st District	3 years	May 1968-May 1971	Henry A. Davidson Essex
2nd District	3 years	May 1968-May 1971	Eugene V. Resnick Bergen
Public Health:			
1st District	3 years	May 1968-May 1971	Henry J. Konzelmann Union
4th District	3 years	May 1968-May 1971	Anthony P. DeSpirito Monmouth
Public Relations:			
1st District	3 years	May 1968-May 1971	S. William Kalb Essex
4th District	3 years	May 1968-May 1971	John P. Kengeter Ocean
Standing Committees:			
Annual Meeting:	3 years	May 1968-May 1971	James A. Rogers Passaic
Finance and Budget	3 years	May 1968-May 1971	Charles A. Landshof Hudson
Medical Defense and Insurance	3 years	May 1968-May 1971	Jesse Schulman Ocean
Medical Education	3 years	May 1968-May 1971	Frank S. Forte Essex
Publication	3 years	May 1968-May 1971	James J. Fitzpatrick Mercer
Woman's Auxiliary Advisory	3 years	May 1968-May 1971	Ralph K. Bush Camden

1968 Annual Meeting

General Session

Sunday, May 19, 1968 — 4:00 p.m.

Presiding
Louis K. Collins, M.D., President

Inaugural Address of Incoming President
John F. Kustrup, M.D., Trenton
President-Elect

Message from the American Medical Association
Dwight L. Wilbur, M.D., San Francisco
President-Elect

1968 Annual Meeting

DINNER-DANCE

Monday, May 20 — 7:00 p.m.

Honoring
President and Mrs. Louis K. Collins

Toastmaster
Richard I. Nevin

Welcome
Mrs. David E. Zuckerman, President,
Woman's Auxiliary

Introductions
Mrs. John F. Kustrup, President-Elect,
Woman's Auxiliary
John F. Kustrup, M.D., President-Elect

Presentations

Fellow's Key:
To: Louis K. Collins, M.D.
By: Joseph R. Jehl, M.D., Immediate Past-President

Fellowette's Pin:
To: Mrs. David E. Zuckerman, President,
Woman's Auxiliary
By: Louis K. Collins, M.D., President

Speaker:
The Honorable John E. Hunt, Member of Congress
from 1st District — "Apathetic Attitudes"

Music and Dancing
Martin King Orchestra Associates

1968 Annual Meeting

SCIENTIFIC PROGRAM

Sunday, May 19
Monday, May 20 and Tuesday, May 21
Wednesday, May 22

Special Scientific Sessions
Section Sessions
Clinical Pathologic Conference

Special Scientific Sessions

Sunday, May 19—1 to 5 p.m.

Religion And Medicine

(Arranged and presented in cooperation with The Academy of Medicine of New Jersey)

9:30 a.m. / Coffee and Buns

9:45 a.m. / Symposium on Religion and Medicine
Moderator: JOHN S. MADARA, M.D., Salem; Chairman, Section on General Practice, The Academy of Medicine of New Jersey

Panelists: RABBI REUBEN R. LEVINE, Temple Beth Ahm, Springfield

REVEREND WILLIAM J. BOONE, Chaplain, The Mountainside Hospital and Montclair Community Hospital, Montclair

REVEREND JOSEPH P. SHERER, Roman Catholic Chaplain, Newark City Hospital, Newark

Religion and medicine are the twin sisters of healing. Here we will discuss the relationship between the two, in the light of the "new morality" and the rapid explosion of medical knowledge and technics which demand moral interpretation.

Religious leaders must involve themselves in the problems which face the practitioner in his daily life: the role that religion plays in the recovery from illness . . . moral and social aspects which affect health, such as the rise of delinquency and crime, smoking, excess drinking, drug addiction, *the population explosion and birth control, the prolongation of life, the morality of transplants, and finally, the definition of death.*

Because of the nature of this program, it is felt that more benefit can derive from round-table discussion than from a formal presentation of papers. We hope that an interested and concerned audience will take an active part.

Suicide

(Arranged and presented in cooperation with the Division of Mental Health and Hospitals, New Jersey State Department of Institutions and Agencies)

1:00 p.m. / Symposium: Physician and the Suicidal Patient

Moderator: JAMES B. BUTLER, M.D., Chief Medical Consultant, New Jersey State Department of Institutions and Agencies, Trenton.

Recognition of Warning Signs of Suicide by the General Practitioner

DOULAT KESWANI, M. D., Director, Raritan Bay Mental Health Center, Roosevelt Hospital, Metuchen

Summary not received

Organization of a Suicide Prevention Center

HARRY H. BRUNT, Jr., M. D., Medical Director, New Jersey State Hospital, Ancora; and Adjunct Associate Professor of Psychiatry, Temple University School of Medicine, Philadelphia

Recognizing suicide as a serious public and mental health problem, Ancora State Hospital directed attention to the organization of a hospital-based, anti-suicide program to serve the community. Our state has had more than 500 of the 20,000 suicides recorded annually in this country. Particularly motivating Ancora's establishing of a suicide center was the realization that the hospital's seven-county

catchment area in southern New Jersey had a higher suicide rate than that of our State as a whole.

Within the confines of a limited budgetary allowance for its goal of effecting an anti-suicide program, Ancora directed its efforts toward a suicide prevention telephone service. Staff discussions revolved around the minimal requirements to launch such a project—the mechanics of telephone calls, the basic psychologic principles of telephone interviews, a meaningful questionnaire, the selection of participating hospital staff, as well as the utilization of appropriate resources in the community.

Set into operation in February 1966, the Ancora Suicide Prevention Telephone Service has operated on an around-the-clock basis including nights, weekends, and holidays. Calls coming in on the special telephone line, with its advertised and easily remembered number (561-1234) are immediately directed to senior psychiatrists on the hospital staff. These selected staff members serve on a daily rotating basis and each has a special telephone installation in his home on the hospital grounds, thus assuring coverage at all times.

Exemplifying Ancora's constant endeavor to go beyond its obligations as a State hospital in providing a service to the community, this suicide prevention program has, in effect, placed the hospital right in the middle of every community in southern New Jersey.

Death by Suicide in the Hospital: An Analysis of 20 Therapeutic Failures

MICHAIL ROTOV, M.D., Director of Training, New Jersey State Hospital, Trenton

The author examines the records of 20 patients who committed suicide during or shortly after hospitalization. Without regard to statistics, the circumstances of suicide are being analyzed as they are reflected in patients' records. The following variables receive special attention: (1) therapeutic regime, (2) doctor-patient relationship, (3) adequacy of preventive measures, (4) missed clues of suicidal intent. The most striking aspect appears to be the nature of doctor-patient relationship, with seven cases showing the evidence of disturbance. In five cases, countertransference on the part of the physician is vividly reflected in his own progress notes. This interfering emotion clouded the doctor's judgment and prevented him from taking proper therapeutic measures. Among the missed clues, the patient's projective concern with his relatives' lives is of particular interest. The examination of the doctor's personal characteristics indicates that outstanding physicians are not exempt to this type of failure. However, there is considerable clustering of suicide cases around a meek, friendly, or undecisive doctor, and particularly around a physician who shows the following traits: therapeutic nihilism, boredom at work, adherence to routines, stubbornness, and unreceptiveness to advice and to criticism.

Scientific Section Sessions

Monday Morning, May 20

Joint Session

Sections on:

Obstetrics and Gynecology
Urology

Presiding

Harold B. Schwartz, M.D., Chairman
Section on Urology

9:00 a.m. / Election of Officers for 1969

9:15 a.m. / Anatomy and Physiology of Female Urethra

BERNARD D. PINCK, M.D., Director, Department of Urology, Passaic General Hospital; and Associate Professor of Urology, New York Medical Center, New York

Factors relating to the structural and functional properties of the female urethra conducive to incontinence are reviewed. Congenital aberrations, the influences of stress and trauma, and the effect of disease are evaluated. Aspects of anatomy and physiology relating to surgical approach are considered.

9:35 a.m. / Vaginal Approach to Incontinence

HUMBERT L. RIVA, M.D., Professor and Chairman, Department of Gynecology and Obstetrics, New Jersey College of Medicine and Dentistry, Jersey City; and Consutant in Obstetrics and Gynecology, St. Vincent's Hospital and Medical Center, New York

Summary not received

9:55 a.m. / Suprapubic Approach to Incontinence

DENIS CAVANAGH, M.D., Professor and Chairman, Department of Gynecology and Obstetrics, St. Louis University School of Medicine, St. Louis.

The first step in the management of the patient with stress incontinence is adequate evaluation. A definite program of pre-treatment investigation should be followed. Some patients require no operation. Of those patients requiring operation, the approach most suitable for the individual patient should be chosen. The indications for a suprapubic approach to operative treatment will be discussed. The types of operation available will be described and their relative merits discussed.

10:20 a.m. / New Approach to Incontinence via Urethral Lengthening

GUY W. LEADBETTER, JR., M.D., Professor and Chairman, Department of Urology, University of Vermont College of Medicine, Burlington, Vermont

Eighteen patients have been operated upon for total urinary incontinence. Cause of incontinence has been Y-V plasty, transurethral resection of bladder neck in females, vesicovaginal fistula with destruction of urethra, destruction of the bladder neck and external sphincter by ectopic ureterocele, congenital absence of external sphincter. The technic here is different in that the ureters are reimplanted posteriorly and the trigone is used to form a sphincter. Results of this procedure have been good and over a period of eight years experience has been gained so that we know better on which patients surgery should be performed.

10:45 a.m. / Indications for Estrogen in the Postmenopausal Female

HERBERT S. KUPPERMAN, M.D., Associate Professor of Medicine, New York University Medical Center, New York; and Endocrine Consultant. Veterans Administration Hospital, Bronx

Summary not received

11:10 a.m. / Contraindications for Estrogen in the Postmenopausal Female

JAMES L. BREEN, M.D., Gynecologist and Obstetrician-in-Chief, Newark City Hospital; and Associate Professor, Department of Gynecology and Obstetrics, New Jersey College of Medicine and Dentistry, Jersey City

In an era where the great debate centers about the prolonged use of estrogen replacement therapy in the post-menopausal women, situations are presented where such therapy is contraindicated.

11:30 a.m. / Visit to Exhibits

Section on:

Orthopedic Surgery

Presiding

William U. Cavallaro, M.D.

9:15 a.m. / Election of Officers for 1969

9:30 a.m. / The Silver Procedure in Temporomandibular Joint Diseases

JOHN W. BROMLEY, M.D., Associate Attending Orthopedic Surgeon, St. Joseph Hospital, Paterson; and Assistant Clinical Professor, New York University Medical College, New York
and

PHILIP COHEN, M.D., Associate Attending Orthopedic Surgeon, St. Joseph Hospital, Paterson; and Instructor, New York University Medical College, New York

This paper discusses the anatomy and pathology of certain temporo-mandibular joint disturbances, with particular reference of recurrent dislocation and chronic tear of the temporo-mandibular meniscus.

Seven cases of temporo-mandibular joint disease have been treated by the surgical procedure described by Silver with excellent results in all cases. Illustrative cases are presented together with an accurate description of the operative procedure.

10:00 a.m. / Recurring Dislocation of Patella

HAROLD T. HANSEN, M.D., Attending Orthopedist, New Jersey Orthopaedic Hospital, Orange
and

ROBERT V. FINNESEY, M.D., Attending Orthopedic Surgeon, New Jersey Orthopaedic Hospital, Orange

We are presenting a brief review of the literature on recurrent dislocating patellae with suggestions concerning the development of normal versus abnormal formation of the patella and intercondyllar notch in certain cases.

A means of surgically correcting this will be discussed.

10:30 a.m. / Coffee Break

10:45 a.m. / Background of Ski Injuries, A Review

JOHN R. MERENDINO, M.D., Resident in Orthopedic Surgery, Monmouth Medical Center, Long Branch
and

OTTO LEHMANN, M.D., Director of Fracture Service, Monmouth Medical Center, Long Branch

The history of skiing is reviewed together with the development of the equipment and the environment of today's most popular winter sport. The speaker will analyze various factors involving responsibility in the production of ski injuries. This will be documented by case reports.

The presentation is illustrated by slides.

11:15 a.m. / Cineradiography of the Abnormal Neck

J. WILLIAM FIELDING, M.D., St. Luke's and Polyclinic Hospitals, New York

Summary not received

11:45 a.m. / Visit to Exhibits

12:15 p.m. / Luncheon — New Jersey Orthopaedic Society

Reservations: WILLIAM U. CAVALLARO, M.D., 382 Springfield Ave., Summit

Joint Session

Sections on:

Allergy
Otolaryngology
Pediatrics

Presiding

James E. Brennan, M.D., Chairman
Section on Otolaryngology

9:30 a.m. / Election of Officers for 1969

9:45 a.m. / Symposium on Serous Otitis Media

Moderator: JAMES E. BRENNAN, M.D., Attending in Otolaryngology, Cooper Hospital, Camden

From the Viewpoint of the Otolaryngologist

HARVEY P. YEAGER, M.D., Irvington; Adjunct Otolaryngology, Newark Beth Israel Hospital

Serous otitis media in children appears on the "rise." Whether this is a true increase in incidence, or a mirror of a higher degree of suspicion, is difficult to ascertain. In general, the otolaryngologist has taken a rather aggressive approach to this problem. If there is persistent fluid, myringotomies are performed usually with adenoidectomy. When the fluid recurs, then repeat myringotomies are done with insertion of aeration devices. The aim of this surgical approach is the restoration of hearing — or at least a staying action, so that the child will remain effective in his environment.

From the Viewpoint of the Pediatric Allergist

VICTOR L. SZANTON, M.D., Assistant Professor of Pediatric Allergy, Albert Einstein College of Medicine of Yeshiva University, New York

Summary not received

From the Viewpoint of the Pediatric Otolryngologist

SYLVAN E. STOOL, M.D., Assistant Professor of Otolaryngology and Pediatrics, University of Pennsylvania School of Medicine; and Chief of Otolaryngology, The Children's Hospital, Philadelphia

Serous otitis media is a frequent occurrence in children. Its incidence appears to be increasing. The disease may be related to anatomic abnormality, adenoid tissue, antibiotic therapy, allergy, or immunologic deficit. These several factors will be discussed and illustrated.

A Comprehensive View

FREDERICK HARBERT, M.D., Professor and Head, Department of Otolaryngology, Jefferson Medical College, Philadelphia

Two clinical types of serous otitis media should be distinguished. One form usually follows a respiratory infection, is characterized by mucoid or opalescent secretions, and is usually self-limited with or without treatment. Another form has an insidious onset, has thin straw colored or gelatinous secretions, and tends to be persistent or recurrent. In the present state of our knowledge we must confess our ignorance of the causes and treatment of this type of otitis media and offer only palliative treatment in the form of repeated aspirations or a plastic prosthesis through the drum.

11:00 a.m. / Panel Discussion

11:45 a.m. / Visit to Exhibits

Joint Session

Sections on:

Anesthesiology
Gastroenterology and Proctology
General Practice

Presiding

Carl A. Restivo, M.D., Chairman
Section on General Practice

9:30 a.m. / Election of Officers for 1969

9:45 a.m. / Symposium on Ano-Rectal Disease

Moderator: SALVATORE J. DETRANO, M.D., Chairman, Section on Gastroenterology and Proctology, Union City

Diagnosis of Ano-Rectal Disease

EUGENE P. SALVATI, M.D., Associate Attending Surgeon, Muhlenberg Hospital, Plainfield

This will not be a paper for publication but simply a ten minute discussion of the differential diagnosis of common ano-rectal problems such as levator syndrome, fissure, perirectal abscess, fistula, hemorrhoids, pruritus ani, proctitis, polyp, and diverticulitis.

Management of Ano-Rectal Problems

STUART H. Q. QUAN, M.D., Assistant Attending Surgeon, Colon and Rectal Service, Memorial Hospital for Cancer and Allied Diseases, New York

Summary not received

Local Anesthesia for Ano-Rectal Surgery

JACK W. McELWAIN, M.D., Bethpage, New York; Director of Colon and Rectal Surgery, Meadowbrook Hospital, East Meadow, New York

Summary not received

Anesthesia for Ano-Rectal Surgery

JOSEPH F. LUTZ, M.D., Attending Anesthesiologist, Orange Memorial Hospital

After taking into account the advantages and disadvantages of various types of anesthesia available, it is believed that lumbar epidural anesthesia suits the situation best in ano-rectal surgery. A simple, reliable method of performing such a block with a blunted needle, to help prevent piercing the dura, is introduced. The pertinent anatomy is reviewed. Patient acceptance of epidural anesthesia is good compared to spinal anesthesia which many resist. The importance of pre-operative preparation is stressed.

11:00 a.m. / Panel Discussion

11:45 a.m. / Visit to Exhibits

Joint Session

Sections on:

Clinical Pathology Metabolism

Presiding

Arthur Krosnick, M.D., Secretary
Section on Metabolism

9:30 a.m. / Election of Officers for 1969

9:45 a.m. / Symposium on the Methods and Value of Routine Blood Chemistry Screening

Moderator: ARTHUR KROSNICK, M.D., Coordinator, Diabetes, Endocrine and Metabolic Disease Program, Division of Chronic Illness Control, New Jersey State Department of Health, Trenton

Panelists: Clinical Pathologist, S. RAYMOND GAMBINO, M.D., Director of Laboratories, Englewood Hospital; and Assistant Professor of Pathology, Columbia University, New York

Summary not received

Internist, CLIFFORD W. GURNEY, M.D., Professor and Chairman, Department of Medicine, Rutgers Medical School, Rutgers — The State University, New Brunswick

Summary not received

Epidemiologist, EDWARD H. KASS, M.D., Associate Professor of Bacteriology and Immunology, Harvard Medical School; and Director, Channing Laboratories, Boston City Hospital, Boston

The philosophy behind our screening procedures will be reviewed. An estimate of "return" from screening and of possible new areas for screening activity can be made. The difficulties in screening for diseases for which there are no effective therapies, will be balanced against the need for detecting incipient remediable disease, and a small list of situations in which screening seems genuinely useful will be presented.

11:00 a.m. / Panel Discussion

11:45 a.m. / Visit to Exhibits

Monday Afternoon, May 20

Section on:

Chest Diseases

Presiding

Raymond E. Miller, M.D., Chairman
Section on Chest Diseases

2:00 a.m. / Election of Officers for 1969

2:15 p.m. / The Role of Angiography in the Diagnosis of Pulmonary Diseases

NICHOLAS J. DEMOS, M.D., Assistant Professor of Surgery, New Jersey College of Medicine and Dentistry; and B. S. Pollak Hospital for Chest Diseases, Jersey City

Pulmonary angiography has been of great value in establishing the diagnosis of many cardiopulmonary diseases. Cor pulmonale, emphysema or bronchitis may be investigated by pulmonary angiography. On the other hand operation can be avoided if cancer invasion of the great vessels is found on angiography. Most important, though, surgical diseases can be adequately diagnosed by angiography and properly treated. Such diseases include pulmonary arteriovenous fistulae, anomalous pulmonary venous drainage, superior vena caval syndrome, and pulmonary embolism. Other diseases such as hypoplasia or agenesis of one lung can be properly diagnosed. Representative slides will be shown and a short movie of excision of pulmonary arterio-venous fistula will be presented.

2:40 p.m./ Radioactive Lung Scanning in the Diagnosis of Pulmonary Diseases

JOSEPH F. INZINNA, M.D., Director of Radiology, Jersey City Medical Center; and Instructor in Clinical Radiology, New Jersey College of Medicine and Dentistry, Jersey City

Scintillation scanning of the lungs employing radioiodinated macroaggregated albumin is a simple and reliable diagnostic study without risk of morbidity. It indicates regional pulmonary ischemia far more often and earlier than conventional x-ray films. It is an important screening test in patients presenting symptoms of pulmonary embolism. Scans may be repeated safely at frequent intervals to follow the course of such embolism and other diseases which may alter pulmonary arterial blood supply, such as obstructive emphysema and various types of parenchymal diseases. It is useful in selecting patients for pulmonary angiography and may be helpful in planning surgical attack.

3:00 p.m. / The Current Status of Hyperbaric Oxygen in the Treatment of Pulmonary Diseases

THEOBALD REICH, M.D., Associate Professor of Clinical Surgery, Director of Hyperbaric Facility, Institute for Rehabilitation Medicine, New York University Medical Center, New York

Hyperbaric oxygenation has proved life saving in hypoxia caused by pulmonary insufficiency. The benefit results from increased solubility and diffusibility of oxygen under increased pressure. Low arterial blood oxygen content during defective diffusion and ventilation — perfusion especially are benefited. Severely hypoxic patients with various acute lung diseases became adequately oxygenated only when given hyperbaric oxygen. Initial arterial blood oxygen tensions were as low as 40 mm of mercury even while ventilated artificially through a tracheostomy.

Extended treatment requires continuous monitoring of blood gases and adjustment of inspired oxygen tensions in order to prevent pulmonary oxygen toxicity which itself may cause hypoxia.

3:25 p.m. / Newer Concepts in the Therapy of Pulmonary Malignancies

BERNARD J. KOVEN, M.D., Assistant Professor of Medicine, Director of Oncology Division, New Jersey College of Medicine and Dentistry, Jersey City; and Assistant Attending Physician, Memorial Sloan-Kettering Cancer Center, New York

The 5-year survival rate in lung cancer treated by any single modality has been dismally low. For this reason, attempts to combine chemotherapy and/or x-ray therapy with surgical resection have been undertaken. This paper reviews the current status of these efforts.

3:45 p.m. / Discussion

4:30 p.m. / Visit to Exhibits

Section on:

Psychiatry and Neurology

Presiding

Joseph C. Borrus, M.D., Chairman
Section on Psychiatry and Neurology

2:00 p.m. / Election of Officers for 1969

2:15 p.m. / Symposium on Psychedelic Drugs: Their Effects on the Individual and Society

Neuropharmacology

HENRY B. S. MURPHREE, JR., M.D., Neuropharmacology Section, New Jersey Neuropsychiatric Institute, Princeton; and Lecturer in Pharmacology, Hahnemann Medical College, Philadelphia

Drugs generally designated as "psychedelic" have become foci for emotional and not always entirely rational reactions on the part of takers and of society at large. Takers overvalue what they think are the beneficial effects of these drugs. Society tends to overestimate the deleterious effects of the drugs as such while failing to recognize that all drug misuse is symptomatic of underlying psychiatric disturbance whether the drug be LSD, alcohol, or aspirin. So-called "psychedelic" effects can be elicited with drugs not usually called "psychedelic" or with no drug at all. And all "psychedelic" drugs have fairly prominent pharmacologic actions, the significance of which is usually lost in the psychosocial haze. This presentation will classify these drugs and describe their effects.

Clinical and Experimental

THOMAS E. SHOEMAKER, II, M.D., Assistant Clinical Director, The Carrier Clinic, Belle Mead

The only psychedelic drug which has been used to any extent clinically is d-lysergic acid diethylamide (LSD) and this paper will be confined to observations on this drug. Enthusiasm for the clinical use of LSD, while still strong in some areas, has certainly declined. Some feel that the drug is dangerous and should not be used.

The hallucinogenic properties of LSD were discovered by accident and it was then felt that this might produce an ideal "model schizophrenia." This was not true. The drug was then used in many forms of mental illness with numerous favorable reports, especially with alcoholism. The writer has had some personal experience with the use of the drug in treating patients. Many of these studies have been criticized. There is also concern about the possible physical damage such as chromosomal breakage and possible damage to the microcirculation in the brain.

Organization of a City Drug Program

HECTOR CORRAL, M.D., Consultant to Monmouth County Commission for Drug Addiction, Red Bank

Before outlining the organization of a program of prevention and treatment for psychedelic drug addicts, the author briefly discusses the psychiatric, medical, philosophical, and social factors involved and originated by this reality: "The Psychedelic Drug Addict."

References to the century old literature (psychiatric or not) upon the use of hallucinogens to the peculiar psychiatric-social upheavel of the present young generation (ages 14 to 29) and its implications in their adjustment, rejection, and integration within our middle class social structure are made — also some elaboration about the most important writers, who heralded in the last century the present "Zeiteist."

A program is outlined covering the major areas of (1) Prevention, (2) Treatment, and (3) Rehabilitation — Stage (1) involves society at large but specifically certain groups like health professionals, police, educational groups, religious groups, and the youngsters themselves. Stage (2) covers the need and feasibility of setting up adequate therapeutic outfits in hospitals or independently from medical services. Stage (3) describes the need for

developing a compulsory system to help the youngster reunite himself to a society from which he is alienated. The need for the cooperation of government and private groups is emphasized since the magnitude of the addiction problem makes necessary the involvement of all concerned in the better functioning of society.

Legal Implications and Impact on Private Practice

NOEL C. GALEN, M.D., Assistant Clinical Professor of Psychiatry, New York University College of Medicine, New York; and Attending in Psychiatry, Englewood Hospital

This paper will consist of a review of the current legislation in New Jersey and neighboring states affecting L.S.D., including regulation and reporting. Other factors to be discussed will be responsibility of the physician who acquires knowledge of L.S.D. use toward the patient, his family, and the community. The prospect of new legislation to regulate L.S.D. will also be discussed.

Discussor: HENRY A. DAVIDSON, M.D., Cedar Grove

4:30 p.m. / Visit to Exhibits

Joint Session

Sections on:

Radiology
Surgery

Presiding

Stephen H. M. Plum, M.D., Chairman
Section on Surgery

2:00 p.m. / Election of Officers for 1969

2:15 p.m. / Symposium on Pulmonary Embolism

Radiographic Diagnosis

F. THOMAS WITOMSKI, M.D., Associate Radiologist, Middlesex General Hospital, New Brunswick

Summary not received

2:40 p.m. / Medical Management

STUART W. COSGRIFF, M.D., Associate Attending Physician, Presbyterian Hospital; and Associate Professor of Clinical Medicine, Columbia University College of Physicians and Surgeons, New York

Summary not received

3:05 p.m. / Vena Caval Surgery

E. BRUCE HALLETT, M.D., Attending Surgeon, Morristown Memorial Hospital, Morristown

Pulmonary embolism is a major hazard in the natural history of deep venous thrombosis. The modification of this process by caval plication is discussed. The diagnosis, indications, approach, and postoperative care are illustrated and the hazards and complications stressed. Adjunctive caval plication in venous thrombectomy appears to have a place, particularly where residual clot in an extremity is anticipated. Late postoperative sequelae may be minimized with plication technics as opposed to ligation. In carefully selected cases, the procedure may be lifesaving.

3:30 p.m. / Approach by Cardio-Pulmonary Bypass

JOSEPH J. TIMMES, M.D., Director of Cardiovascular Surgery, B. S. Pollak Hospital for Chest Diseases; and Professor of Surgery, New Jersey College of Medicine and Dentistry, Jersey City

Early suspicion of massive pulmonary embolism must be based on nonspecific symptoms and signs. The diagnosis must be confirmed by lung scanning or selective pulmonary angiography, or both.

In patients who fail to respond promptly to medical therapy, surgical embolectomy is recommended. Trendelenberg first suggested this more than half a century ago. Today, this operation is feasible with the availability of disposable, presterilized pump oxygenators that can be primed without blood. During the past three years this operation has been performed with increasing success though not without difficuties.

3:50 p.m. / Panel Discussion

4:30 p.m. / Visit to Exhibits

Section on:

Rheumatism

Presiding

William D. Kimler, M.D., Chairman
Section on Rheumatism

2:00 p.m. / Election of Officers for 1969

2:15 p.m. / Roentgen Findings in Various Types of Arthritis

ROBERT H. FREIBERGER, M.D., Director, Department Radiology, Hospital for Special Surgery; and Associate Professor of Radiology, Cornell University Medical College, New York

The purpose of this presentation is to impart useful information on the interpretation of roentgenograms of arthritic patients and not to provide a complete review of one specific arthritis. Diagnostic features of osteoarthritis, particularly of the weight bearing joints, will be shown, indicating how additional information can be obtained by weight bearing films of the knee. The diagnosis of synovitis of various joints will be discussed and correlated with arthrograms. Diagnostic features of rheumatoid arthritis in peripheral joints and the cervical spine will be shown. Whenever applicable, a short differential diagnosis of lesions producing similar roentgen findings will be included.

2:40 p.m. / Early Synovectomy in the Rheumatoid Child

JOHN L. SBARBARO, JR., M.D., Attending Staff, Children's Seashore House for Invalid Children, Atlantic City; and Assistant Professor Orthopedic Surgery, University of Pennsylvania School of Medicine, Philadelphia

Discussor: PETER W. VANACE, M.D., Atlantic City

There have been only sporadic reports concerning the efficacy of early synovectomy in the rheumatoid arthritic child. Very little is known about the subsequent course of the disease or the local response of the surgically treated joint. Of great importance is the effect of synovectomy on the developing epephysis.

This report will describe our experience with early synovectomy in the systemic form of rheumatoid arthritis. Over the past two years, ten patients have been treated with selective synovectomy. Where feasible, the opposite joint has been utilized as a clinical control. The ankles, knees, hips, wrists, and finger joints have been evaluated with 15 surgical procedures. Average age was 9.7 with the youngest being 6 years and oldest 17 years.

This is an on-going project and it will not be possible to state any definite conclusions for a number of years; however, early results have been quite encouraging. Our indications, contraindications, and results thus far will be discussed.

3.25 p.m. / Severe Pernicious Anemia and Hypothyroidism Precipitating Rapid Severe Degeneration of the Hip Joints—Case Report

SOL LUBIN, M.D., Assistant Physician, Cooper Hospital, Camden; and Instructor in Medicine, Jefferson Medical College, Philadelphia
and
HENRY H. SHERK, M.D., Associate in Orthopedic Surgery, Cooper Hospital, Camden; and Instructor in Orthopedic Surgery, University of Pennsylvania School of Medicine, Philadelphia

Summary not received

4.05 p.m. / Discussion

4:30 p.m. / Visit to Exhibits

Tuesday Afternoon, May 21

Joint Session

Sections on:

Cardiovascular Diseases Medicine

(Cosponsored by Bergen County Heart Association)

Presiding

Theodore H. Goldberg, M.D., Chairman
Section on Cardiovascular Diseases

2:00 p.m. / Election of Officers for 1969

2:15 p.m. / The Role of the Internist in the Care of the Critically Ill
Moderator: JACOB L. DROSSNER, M.D., Chairman, Section on Medicine, Pennsauken

Respiratory Management of the Critically Ill Patient
STEPHEN M. AYRES, M.D., Chief, Cardiopulmonary Laboratory, St. Vincent's Hospital, New York

Abnormalities in alveolar-capillary gas exchange are extremely common in the critically ill patient and may lead to serious cardiac arrhythmias. Diffuse atelectasis occurs in the most bedridden patients, produces veno-arterial shunting, hypoxemia, hyperventilation and alkalosis. Less commonly, overall ventilaton is decreased leading to respiratory acidosis. Pulmonary physiotherapy, administration of humidified and warmed oxygen, intubation, intermittent positive pressure breathing, and total control of ventilation with therapeutic paralysis may be necessary to control hypoxemia. This presentation discusses the indication for each therapeudic modaliy.

Power Failure — Shock and Heart Failure in the Acute Coronary Patient

JOHN T. KIMBALL, JR., M.D., Associate Director, Coronary Care Unit, New York Hospital-Cornell Medical Center; and Clinical Assistant Professor of Medicine, Cornell University Medical College, New York

Two hundred and fifty patients with acute myocardial infarction were treated in the New York Hospital-Cornell Medical Center Coronary Care Unit (CCU) during a two year period. One-third of the patients developed clinical signs of mild to moderate congestive heart failure. One-third were in severe heart failure (pulmonary edema) or frank cardiogenic shock and one-third had no signs of cardiac decompensation. The mean patient age, the incidence of life-threatening arrhythmias, cardiac arrest, and hospital mortality progressively increased as clinical signs of cardiac decompensation worsened. The early, aggressive use of drugs and electrical technics to control cardiac decompensation, potentially lethal arrhythmias and cardiac arrest were associated with a decline in

hospital mortality for patients treated in the CCU unless cardiogenic shock was present. Hospital mortality for patients with shock remained 80 per cent.

A physiologic approach to the treatment of pulmonary edema and cardiogenic shock will be discussed.

Oliguria in the Critically Ill Patient — Differential Diagnosis and Management

NORMAN LASKER, M.D., Assistant Attending in Medicine, B. S. Pollak Hospital; and Associate Professor of Medicine, New Jersey College of Medicine and Dentistry, Jersey City

Summary not received

3:20 p.m. / Question and Answer Period

3:30 p.m. / Coronary Care in the Community Hospital — Results, Problems, and Prospects

Moderator: THEODORE H. GOLDBERG, M.D., Chairman, Section on Cardiovascular Diseases, Westwood

The Hospital of 500 Beds and Over — The Role of the House Staff

GEORGE T. HARE, M.D., Assistant Physician, Cooper Hospital, Camden; and Instructor in Medicine, Jefferson Hospital, Philadelphia

Coronary Care Units are now found in most community hospitals. The form of the unit will vary, but they all have been devised to provide intensive care for the coronary patient, and to reduce mortality. We do not feel that a Coronary Care Unit in a large community hospital can function at optimum without an adequate number of house staff members. These members must be trained in cardio-pulmonary resuscitations and the treatment of cardiac emergencies. The training of the house staff must be a continuous process, and each year should be a re-education in coronary care.

Results in Community Hospitals — Impact on a County

MILTON M. WIENER, M.D., Attending in Medicine, Hackensack Hospital
and

JEROME D. GOLDFISCHER, M.D., Assistant Attending in Medicine, Englewood Hospital; and Instructor, Department of Medicine, Albert Einstein College of Medicine, New York

Summary not received

How Much Responsibility for the Nurse?

MRS. CAROL P. GERMAIN, R.N., Instructor, Rutgers College of Nursing, Continuing Education Program for Nurses, New Brunswick

Determinants limiting or expanding the responsibility of the coronary care unit nurse in the one dependent area of function in nursing practice — medical therapeutics — will be discussed. Problematic situations arising from actual practice will illustrate the need for medical-nursing collaboration during periods of transition. Recommendations for problem prevention and problem solving will be advanced.

4:00 p.m. / Panel Discussion and Question and Answer Period

4:45 p.m. / Visit to Exhibits

Section on:

Dermatology

Presiding

Harry C. Goldberg, M.D., Chairman
Section on Dermatology

2:00 p.m. / Election of Officers for 1969

2:15 p.m. / The Role of Patch Testing in Industrial Dermatology

SEYMOUR L. HANFLING, M.D., Senior Attending in Dermatology, East Orange General Hospital

The estimated $300,000,000 yearly cost of the industrial dermatologic claims in disability and treatment make accurate diagnosis and prompt, competent care imperative. These dermatoses have been reported by various state labor departments to represent 2/3 of all the industrial diseases. Experienced industrial dermatologists estimate that only 60 to 70 per cent of the cases referred to them as possibly work-connected are compensible. The role of the patch test in the aid of accurate diagnosis is discussed. Patch testing procedures and test result readings are described to enable more physicians to become more proficient in this technic. Accurate histories and proper patch test technics are emphasized.

Kodachrome transparencies will be projected to illustrate some common skin reactions.

2:35 p.m. / The Relationship of Certain Occupational Contactants to Drug Eruptions

ALEXANDER A. FISHER, M.D., Department of Dermatology, New York University School of Medicine, New York

In some occupations individuals are exposed to chemicals which are either the parent substance of drugs or are immuno-chemically related to systemically administered medications.

Thus mercury compounds are related to mercurial diuretics and calomel. Dyes such as paraphenylenediamine are related to para-aminosalicylic acid, sulfonamides and other "para-amino" compounds.

Hydrazine is the parent chemical from which is derived Apresoline® and isoniazid. Ethylenediamine is the parent substance of certain antihistamines and aminophyllin.

Industrial exposure and sensitization to these compounds may result in a distinctive type of drug eruption known as "Systemic Eczematous 'Contact-type' dermatitis medicamentosa," should the related drug be administered to the sensitized worker.

3:00 p.m. / Skin Bacteria and Their Role in Infection

GAVIN Y. HILDICK-SMITH, M.D., Department of Clinical Research, Johnson & Johnson, New Brunswick

The presentation relates to a review of pertinent data concerning the bacterial flora of the skin and changes that occur in the flora in relation to alterations in environment.

In addition, consideration will be given to the nature of bacteria that are isolated from wounds and their relationship to clinical wound infection.

Principles of prevention and treatment of wound infection will also be considered.

3:20 p.m. / Dermatologic Surgery with Razor Dermatome

MELVIN I. SHOUL, M.D., Department of Surgery, Beth Israel Hospital; and Department of Surgery, Harvard Medical School, Boston

One simple mechanical change converts an ordinary adjustable safety razor and blade into a multipurpose instrument for dermatologic surgery. A simplified new technic for skin grafting is based on this dermatome. Precise split thickness skin grafting was done in the office and outpatient department under local anesthesia. One hundred patients with skin tumors, burns, varicose ulcers, or traumatic defects had good to excellent results with one graft failure. This dermatome was used in an additional 25 patients to biopsy suspected skin malignancies, for definitive excision of superficial benign papillomas or nevi, and for planning down hypertrophic scars.

3:45 p.m. / Discussion

4:30 p.m. / Visit to Exhibits

Section on:

Ophthalmology

Presiding

Humbert M. Gambacorta, M.D., Chairman
Section on Ophthalmology

2:00 p.m. / Election of Officers for 1969

2:15 p.m. / Malignant Melanoma of the Iris

S. LAWRENCE SAMUELS, M.D., Attending in Surgery, Muhlenberg Hospital, Plainfield; and Clinical Assistant Professor of Ophthalmology, New Jersey College of Medicine and Dentistry, Jersey City

Four cases of malignant melanoma of the iris are presented. Each had a different set of symptoms and each poses the problem of early diagnosis and proper disposition.

One-eyed glaucoma in a middle aged person, hyphema of non-traumatic origin, and heterchromia are some of the things which arouse suspicion of a malignant growth of the iris. While enucleation is the safest course, there is justification of less radical means in certain cases.

A recurrent malignant melanoma of the iris and ciliary body is fully described with comments by a number of leading eye pathologists.

2:35 p.m. / Some Observations on Narrow Angle Glaucoma

HAROLD D. BARNSHAW, M.D., Camden; Attending Surgeon, Wills Eye Hospital; and Clinical Professor of Ophthalmology, Temple University School of Medicine, Philadelphia

A short review is presented covering the history, bibliography, and diagnosis of narrow angle glaucoma. A review of the treatment of this type of glaucoma is discussed. Also reviewed are cases of narrow angle glaucoma with a group of patients who had operations in only one eye. Conclusions will be drawn from these cases and suggested method treatment outlined.

2:55 p.m. / Principles in Ophthalmic Plastic Surgery

BYRON C. SMITH, M.D., Chairman, Department of Ophthalmology, Manhattan Eye and Ear Infirmary, New York

The principles involved in the management of any ophthalmic plastic surgical procedure are dependent upon the correct diagnosis. The surgeon must be prepared to change the surgical tactics during surgery any time the tissues of the wound fail to exhibit his anticipated expectations. Essentially this means having readily available unorthodox equipment at all times. Such instruments should be stored and sterilized in the operating room at the time surgery is scheduled.

The surgeon must be informed about the standard means of excising unwanted tissue and replacing it with flaps, grafts, and/or prosthetics. In these designs the surgeon is obliged to be familiar with various types of suturing technics and suture materials available. Collection of fluids, excessive tension, poor circulation, and infection may spell the doom of the finest operation a surgeon is capable of producing. Likewise, surgical dressings may hinder or help healing during the early post-operative period. Post-operative care is just as important as the surgical procedure itself.

3:20 p.m. / Surgical Treatment of Tumors of the Lids

ARTHUR E. SHERMAN, M.D., East Orange; Attending in Surgery, Orange Memorial Hospital

This paper will discuss the surgical management of the commoner malignant and benign tumors of the eyelids encountered in the average ophthalmologist's practice. The choice of surgical procedure depends chiefly on the type, location, and size of the lesion. Most of the procedures discussed will be those that any ophthalmic surgeon should be able to carry out without difficulty, and will be amply illustrated with lantern slides of drawings and typical cases.

3:40 p.m. / Autokeratoplasty — A Film and Discussion

ORAM R. KLINE, JR., M.D., Attending in Surgery, Cooper Hospital, Camden; and Associate Professor of Ophthalmology, Temple University School of Medicine, Philadelphia

This film illustrates the operation Autokeratoplasty. You will see the enucleation of one eye. A graft is then taken from the enucleated eye and is used to replace the diseased cornea of the fellow eye.

4:00 p.m. / Discussion

4:30 p.m. / Visit to Exhibits

Section on:

Plastic and Reconstructive Surgery

(Cosponsored by New Jersey Society of Plastic Surgeons)

Presiding

Merton L. Griswold, Jr., M.D., Chairman
Section on Plastic and Reconstructive Surgery

2:00 p.m. / Election of Officers for 1969

2:15 p.m. / Symposium of Reconstruction of the Face Following the Auto Accident

Moderator: MERTON L. GRISWOLD, JR., M.D., Attending Plastic Surgeon, Muhlenberg Hospital, Plainfield

The Nose

GEORGE C. PECK, M.D., Associate Attending Plastic Surgeon, Beth Israel Hospital, Passaic

One of the most frequently injured parts of the body is the nose, and (as ironic as it may seem) it is probably one of the most neglected parts for treatment. During this panel a discussion with descriptive slides will depict the important overlooked nasal injuries plus a rather different procedure for treatment of the badly fractured nose. The procedure has resulted in a higher degree of excellent results since it gives the surgeon a better control of the fracture. The discussion will also differentiate between the readily diagnosed bony fracture and the so often overlooked and neglected septa cartilage fractures.

The Soft Tissue and Skin

MICHAEL LEWIN, M.D., Attending Plastic Surgeon, St. Joseph's Hopital, Paterson

The front seat passenger is the most vulnerable person in the car. The windshield is responsible for the majority of facial lacerations, but rarely for any facial fractures. Impact against the dashboard, instrument panel, steering wheel, and other parts of the car frequently causes compound fractures of the face in addition to lacerations. If the victim is thrown out of the car, contamination of the wound with foreign material is commonplace and leads to traumatic tattoo.

Lacerations can be of many varieties; sharply incised down to the bone, with or without undermining, jagged with devitalized edges, tangential forming irregular skin flaps, linear or semi-circular (trapdoor flaps). Lacerations are frequently combined with abrasions, complete avulsions, or partial avulsions.

The presentation will include a discussion of injuries of important structures such as eyelids, facial nerve or parotid duct. Both primary and secondary treatment will be reviewed.

The Bony Skeleton

EDWARD N. LUDIN, M.D., Chief of Plastic Surgery, Cooper Hospital, Camden

Consideration of bony injuries to the face, following an automobile accident, demands accurate diagnosis and considered care, reduction, and repair of bone fracture and loss. Perhaps the most frequent error in diagnosis in the accident wards of most hospitals after an automobile accident, is that of facial fracture. The diagnosis of facial fracture can be quite accurate and detailed after a 60 second knowledgeable examination of the face. This will be outlined completely. X-ray is a help, but the physical examination is of primary importance. Injury to the floor of the orbit is probably missed in diagnosis more often than found. Reconstruction of bony injuries evolves around reduction of the various fractures that can occur in the face, and filling out of defects due to the loss of bone or its severe comminution. Various methods are successfully used to accompish this, but the best usually will be internal wiring and fixation of fractures. Replacement of lost bony tissue can be done with either grafts or the use of newer synthetic materials well tolerated by the body. Thus, an individual, even though sustaining severe facial bony injuries in an automobile accident, can return to society with excellent function and appearance.

Late Complications

JEROME GELB, M.D., Irvington; Attending Plastic Surgeon, Newark Beth Israel Hospital

Complications following facial injuries depend on the extent of the original trauma. It may be the minor foreign body or the major anatomical loss of an ear or nose. Between these extremes are the scar deformities, soft tissue loss, nerve paralysis, displacement and malunion of bony structures, and change in facial outline due to depression. These complications and their treatment will be illustrated and discussed.

3:55 p.m. / Panel Discussion

4:30 p.m. / Visit to Exhibits

Clinicopathologic Conference

(Presented through cooperation of Atlantic City Hospital)

10:30 a.m./Wednesday, May 22, 1968

Case #1

Moderator: Milton Ackerman, M.D., Pathologist
Atlantic City Hospital

Discussor: Rulon W. Rawson, M.D., Dean
New Jersey College of Medicine

A 52-year old male kitchen worker was admitted with shortness of breath, dry cough, edema, and ascites.

The first admission to this hospital had been 16 months previously. At that time, he was admitted with swelling of the legs and shortness of breath. He stated that he had been well until six weeks prior to this, when he had developed shortness of breath and swelling of the legs. These symptoms had become progressively more severe for the six weeks prior to admission. He had had one episode of paroxysmal noctural dyspnea during this six weeks period. There was no hypertension nor rheumatic fever, nor was there any family history of heart disease. His past medical history revealed no serious illness nor hospitalizations nor allergies. The family history was stated to be non-contributory. He smoked a pack of cigarettes every three days and had stopped one month prior to admission. The record stated that he drank moderately.

System review was essentially negative. At this time, his temperature was 97.8; pulse 110; respirations 28, and blood pressure 120/100. He was dyspneic. The head and neck were negative. The neck veins were described as moderately distended at 45 degrees. The chest showed equal expansion. The heart showed a point of maximum intensity at the fourth interspace lateral to the mid-clavicular line. There were no thrills nor heaves. There was a Grade II apical systolic murmur. There was a loud second heart sound. The lungs were dull to percussion at the bases, and there were moist rales at the right base. The abdomen was soft. A smooth, non-tender liver edge was present four fingers breadth below the right costal margin. The extremities showed good pulsations with a 3 plus pretibial edema. The neurological examination was grossly normal.

The red count on admission was 4.139 million; hemoglobin 13.1 gms.; MCH 29; WBC 17,600 (P 66; Promelyo 4; L 26; M 2; Eos 2). A urinalysis showed a specific gravity of 1.018; pH of 5.5; a trace of albumin, and 0-1 WBCs and RBCs/H.P.F. The sugar was 85. The BUN was 27. The potassium was 3.8 meq/1; sodium 139 meq/1; chlorides 102 meq/1, and CO_2 25 meq/1. A serology was negative. A urine was negative for bile and showed 0.6 E.U. urobilinogen. A prothrombin time was 16 secs; 65%. A Lee-White coagulation time was 8 min; 25 secs. A SGOT, six days after admission, was 24. A LDH was 620. Electrolytes, at this time were—sodium 132 meq; potassium 4.3; chlorides 9.5. A sputum culture was reported as Alpha hemolytic Strep. and N. catarrhalis. A bilateral thoracentesis was performed. The fluid from the left chest showed a specific gravity of 1.012; contained 1.2 gm. of protein; 1,476 RBCs/cm., and 4,484 WBCs/cm. The fluid from the right chest had a specific gravity of 1.010 and contained .825 gms. of protein. The white count on this was 1,532; the red count 2,418. A cell block preparation on this material reported suspicious cells on both sides. A PBI was reported 4.5 micrograms.

A chest x-ray, on the day of admission, was reported as "cardiac enlargement with congestive heart failure." Four days later, a second chest x-ray was reported the same. An EKG, on admission, reported sinus tachycardia with a pattern suggesting left ventricular hypertrophy. Six days later, a repeat EKG noted sinus tachycardia; occasional ventricular premature systoles, and evidence of left ventricular hypertrophy. There was a note that there was an "increased strain pattern since the admission EKG." On the 11th hospital day, an EKG reported as sinus rhythm with occasional ventricular premature systoles. The left ventricular strain pattern was similar to the previous EKG, and there was a note "probably no excessive digitalic effect." The patient was placed on bed rest, soft salt-poor cardiac diet; Digoxin, 0.25 mgms. daily. On the second hospital day, penicillin, 600,000 b.i.d. was added to his regime. He was given Aldactone, Aminophylline, and Mercuhydrin. His fluid intake and output, over a six-day period, showed respectively: 1920—975; 920—2100; 920—1900; 1510—1500; 1300—2000; 1550—2200.

He had an uncomfortable hospital course with an aggravating dry cough. He developed rales throughout both chests. The congestive failure did not respond to routine medication. On the sixth hospital day, he had a bilateral thoracentesis with removal of 600 cc. of "bloody fluid" from the right chest and 650 cc. of similar fluid from the left chest. Following the thoracentesis, he showed fairly rapid clinical improvement. His chest became clear; his pedal edema disappeared, and he was discharged 17 days after admission.

He was readmitted about 11 months later with a chief complaint of shortness of breath. In the interim, he had been on Hydroiuril-K, Digoxin, and "water shots," and B_{12}. He denied any intake of alcohol in the year since the previous admission. He stated that he had done fairly well until about four or five weeks previously when he began to notice pedal edema which progressed in intensity and height until it finally involved the genital

region. He developed a chronic dry cough and shortness of breath. On admission, he was severely dyspneic and orthopneic; markedly edematous, and with a dry cough. The blood pressure was 130/110. There was extreme distention of the cervical veins. The right carotid was described as "much more pulsatile than the left." The heart showed no thrills. There was a diastolic rumble in the mitral area. The abdomen was distended with a fluid wave. The liver was three fingers breadth below the costal margin. Thre was massive edema of the legs and the scrotum. A bilateral thoracentesis, on admission, recovered 800 cc. of serosanguineous fluid from the right side and 400 cc. from the left side.

A red count, on admission, was 4.1 million; hemoglobin 11.7 gms.; WBC 7.4 (75; non-fill. 3; L 20; M 2). A urinalysis showed a specific gravity of 1.015; pH of 5.5; 1.4 WBCs, and 1.2 RBCs. The sodium was 136 meq/1; potassium 4.2; chlorides 101, and CO_2 27. A BSP reported as 39% retention. A Lee-White clotting time was 6 min. The prothrombin time was 15 secs; 74%. A bilirubin was—1 min. 0.8; total 1.5. The sedimentation rate was 20. A serology was negative. A Streptolysin titer was reported as over 2500 Todd units. A C-reactive protein was strongly positive. The protein 6.6 (A 2.9; G 3.7). A L-E prep. was reported as negative. A SGOT was 38; a LDH 420. Repeated urinalyses were essentially the same as the first. An Addis count on the urine was within normal limits. The cholesterol was 224; esters 41%. A throat culture was reported as alpha hemolytic Strep., and N. catarrhalis. A urine culture showed non-hemolytic Strep. and Staph albus. A cephalin flocculation was 4 plus in 24 hours. A repeat Streptolysin titer, on the seventh hospital day, showed 1,250 Todd units. A BUN was 17. Several blood cultures were reported as negative. A PBI was reported as 5.3. The thoracentesis fluid removed on admission showed 363 mgms. of protein, and a specific gravity of 1.018. Cytologic studies on this material reported only red blood cells; white blood cells and mesothelial cells.

A chest x-ray, on admission, showed "cardiac enlargement with congestive heart failure and small bilateral pleural effusions." Two days later, repeat studies showed "evidence of congestive failure unchanged from the previous study." An angiocardiogram, on the eighth hospital day, was reported as "no evidence of pericardial effusion" and "slow flow of blood throughout the heart with marked right atrial enlargement and dilatation of the main pulmonary arteries." A repeat chest study on the 14th hospital day showed "marked cardiac enlargement with persistence of a small amount of fluid at the right base and clearing of the previous pulmonary vascular congestion." An EKG, on admission, was reported as "sinus tachycardia with occasional premature ventricular contractions and aberrant ventricular response with delay in A-V conduction (P.R. = .20)" and "left ventricular hypertrophy and strain pattern similar to previous admission." Several days later, an EKG reported "sinus tachycardia with milder ventricular irritability —there is slightly more left ventricular hypertrophy." A protein electrophoresis showed markedly decreased albumin; a slightly increased $alpha_2$; a slightly increased beta globulin, and a markedly increased gamma globulin. Patient was placed on bed rest, low sodium diet, oxygen by tent, Mercuhydrin, Aldactazide, codeine, Coumadin, Digoxin, and phenobarbital. His weight was 176 lbs. on admission and dropped to 129 lbs. on the day before discharge. It was the impression of several attending physicians that a systolic murmur was present on the second hospital day. There is no additional notation concerning this on the record. He diuresed and responded to digitalization. The chest cleared; the edema and ascites were relieved, and he was discharged after 16 hospital days on a regime of Digoxin, Coumadin and Aldactazide.

The final admission, two months later, showed an acutely dyspneic patient with marked distention of neck veins; an apical rate of 130; a systolic ejection murmur; an increased P_2, and anasarca. These signs had slowly reappeared since the prior hospitalization. The blood pressure was 130/80; temperature 98; respirations 22. There were basilar rales on the left side and markedly diminished sounds over the right base. The abdomen was distended with a palpable fluid wave, and there was severe edema of both legs to the groin. The RBC, on admission, was 4.3 million; hemoglobin 12 gms. WBC 7.8 (P 67; non-fil 1; L 30; M a). The urine showed a specitic gravity of 1.021; 35 mgms. of albumin; 1 WBC and 1 RBC/H.P.F. A prothrombin time was 20 secs.; 25%. The sodium was 135 meq; potassium 4.1; chlorides 97, and CO_2 24. The BUN was 32. The serology was negative. The 1 min. bilirubin was 1; total 2. An ASTO was 833 Todd units. The sedimentation rate was 19. A SGOT was 43; a LDH 820. A subsequent SGOT was 550 and the LDH 1,680 on a hemolyzed specimen. The BUN was 43. Fifteen days after admission, a cephalin flocculation was reported as 1.1.

A chest x-ray, on admission, showed "marked cardiac enlargment with evidence of mild pulmonary vascular congestion." An EKG, on admission, showed "first degree A-V block; occasional multifocal premature ventricular contractions, and left ventricular hypertrophy." One week later, there was noted "increasing left ventricular hypertrophy strain pattern," and, another week later, there was noted "increased strain and/or digitalis effect and questionable atrial enlargement." Two days after this, there was reported "probable atrial enlargement." A Dermatologic consultant noted edema of both lower extremities probably due to congestive heart failure with ascites and no primary skin lesions. On the 12th hospital day, a biopsy of skin and muscle from the left thigh was performed. The patient was placed on bed rest, Mercuhydrin, low sodium diet, Demerol, codeine, Aminophylline, Coumadin, Digoxin, oxygen by mask, Mephyton and, terminally, Aramine. He remained in intractable failure. On the fifth hospital day, he complained of abdominal pain and nausea. The Aldacton was cut when he complained of nausea and vomiting following its administration. During the first week of hospitalization, he lost 17 lbs. The edema fluctuated slightly. The diuretics were cut during the second hospital week, but he continued to loose weight. The Digoxin was cut at about the same time. The patient became increasingly refractory to medical counseling and stated that he felt he was dying. He developed a falling blood pressure which, on the day prior to death, was 90/0. He became comatose; developed Cheyne-Stokes respirations, and he died 21 days after admission.

Case #2

Moderator: Ahmad Dibadj, M.D.,
Assistant Pathologist
Atlantic City Hospital

Discussor: Gerard J. Aitken, Jr., M.D.
Director of Medical Education
St. Peter's Hospital, New Brunswick

This is a 72-year-old male who had four admissions to the Atlantic City Hospital over a one-year period.

He first came to us with gastrointestinal bleeding in March 1965. He noted dark red blood on his stool one day prior to admission. Constipation was usually present, and there was no previous history of gastrointestinal bleeding, abdominal pain, vomiting or epistaxis, or weight loss. He was in fairly good health until two weeks prior to admission when he noted weakness, and then he developed swelling of his ankles. A diagnosis of diabetes mellitus was made four years ago, and he was receiving 70 units of NPH insulin. There was a history of tuberculosis at age 15 and jundice at age 20. On physical examination, B.P. was 120/70; pulse 100 and regular; temperature 99°F. He appeared pale. Conjunctivae were pale. A Grade 11 systolic murmur was heard at apex. Liver was palpated 3 fingers below right costal margin, and 2+ ankle edema was present. Rectal examination revealed streaks of blood on the feces. Hgb. was 6.3 gms; RBC was 2.5 million; MCH 25 Mcg. Red cell morphology showed moderate achromia, anisocytosis and, poikilocytosis. 1 nucleated RBC per 100 WBC was seen. WBC was 11,400 with 82% polys, 12% bands and 6% lymphocytes. Platelets were 154,000 and prothrombin 74%. After receiving 4 pints of whole blood, his hemoglobin was 10.8 gms. and hematocrit 37%.

His stool remained dark brown. No gross abnormalities were seen on barium enema or upper gastrointestinal series, and these studies were repeated on three subsequent occasions with similar results. Sigmoidoscopic examination to 15 cms. was negative, and this was the same result obtained by each examiner on three subsequent occasions. Chest x-ray was interpreted as showing old inflammatory changes in right upper lobe. Scout film of abdomen was thought to show an enlarged spleen. The patient was found to have a reactive VDRL and a 4+ Wassermann, and he was treated for syphilis. His blood sugar was 178 mgs.%, and he was well-controlled with 40 units of NPH daily. Other laboratory studies showed 5.1 gms.% total protein with 31. gms.% albumin and 2.0 gms.% globulin. Blood urea nitrogen was 14 mgs.%.

In June, 1965, the patient was admitted the second time for gastrointestinal bleeding. He was passing clots of dark red blood for 3 days. He stated that he lost approximately 20 pounds over the last few months. He was thought to have scleral icterus, and his liver was now enlarged 4-5 fingers below right costal margin. Spleen was not palpable. Rectal examination revealed dark red blood. A Levine tube was passed and clear fluid obtained from stomach. A liver biopsy was performed, but it was inadequate for a proper histologic evaluation. Hgb. was 6.4 gms.% and Hct. was 26%. RBCs were 2.1 million and MCH was 30. Red cell morphology showed moderate achromia and moderate anisocytosis. WBC was 6,400 with 82% polys and 18% lymphocytes. Prothrombin was 74%. Bilirubin, direct, was 0.3 mgs.% and a total of 0.9 mgs.%. Alkaline phosphatase was 3.2 Bodansky units. Platelets were 194,000 and fibrinogen 150 mgs.%. After 4 units of whole blood, his Hgb. was 12.7 gms. and Hct 39%. His stools remained light tan.

On his third admission to the hospital in September, 1965, his chief complaints were severe weakness, shortness of breath, and edmea of the legs for one week's duration. His general appearance presented a striking pallor with marked paleness of his conjunctivae. His neck veins were not distended, and his chest was clear to percussion and auscultation. A Grade III apical systolic murmur was heard at the apex. Liver was palpated 3 fingers below the right costal margin and ankle edema was 4+. No masses felt on rectal, but hematest on stool specimen was positive. Now his Hgb. was 3.7 gms.% and Hct. was 17%. RBCs were 1.5 million and MCH was 24 Mcg. 4 normo-blasts per 100 WBCs were present. Morphology of RBCs showed moderate polychromasia, marked anisocytosis and achromia, and slight poikilocytosis. Reticulocytes were 3%. Platelets were 148,000. Coombs direct and indirect were negative. LDH was 580 BB units. Gastric analysis showed no free acid in fasting specimen and, after stimulation with Histalog, no free acid was found in the 15, 30, or 60 minute specimens. Direct bilirubin was 0.2 mgs.%, and total biliruhin was 0.8 mgs.%. Alkaline phosphatase was 3.0. Total protein was 4.4 gms.%: albumin 2.3 gms.%. Cholesterol was 104 mgs.%, and cholesterol esters were 33%. Partial thromboplastin was 77 secs., and fibrinogen was 300 mgs.%. Prothrombin time was 85%. SGOT was 24 units. A bone marrow was performed, and the interpretation was that megaloblasts were present, and giant granulocytic forms were seen. A Schilling test was performed. 1,000 u.g. Vit. B_{12} given; 1,470 cc. urine collected, and excretion of B_{12} was 22.6%. No intrinsic factor was given because of normal excretion. The patient was treated with Vit. B_{12} 100 u.g. I.M. for a few days, and he received 2 units of packed cells.

His last admission was in October, 1965, with gastrointestinal bleeding for a few days prior to admission. On physical examination, he had a fever of 102°F. Pulse was 100 and regular. His liver was palpated 4 fingers below the right costal margin, and there was 1+ ankle edema. A Levine tube was passed, and no blood was found in the esophagus or stomach. On rectal examination, blood was present on stool. Hgb. was 7.8 gms.% and Hct. was 26%. RBCs were 3 million. MCH was 26 Mcg. Red cell morphology showed moderate achromia and slight anisocytosis. Esophagoscopy was performed, and dark red blood was found oozing down from nasopharynx. No varices were seen. Dark blood was noted over portions of gastric mucosa, but no peptic ulcer was seen. ENT consultation reported an ulceration of the nasal septum. The patient continued to bleed intermittently over the next 3 weeks, and he became lethargic and jaundiced. His bilirubin was 2.1 mgs.%, direct, and 4.1 mgs.% total. Alkaline phosphatase was 7.2 Bodansky units. Prothrombin time was 74%, and partial thromboplastin was 2 minutes. Bone marrow was repeated and showed erythrocytic hyperplasia, normoblastic type. He became comatose and died on 11-16-65.

1968 Annual Meeting

MOTION PICTURE THEATRE

Sunday, May 19, Afternoon
Monday and Tuesday, May 20 and 21
Morning and Afternoon
Wednesday, May 22
Morning

Arranged and presented through the cooperation of the Ciba Pharmaceutical Company, Summit.

10:00 a.m. / Bacterial Meningitis

Through the courtesy of Ayerst Laboratories, you will have the opportunity to see a unique new medical film that discusses concepts in the differential diagnosis and technics of treatment in bacterial meningitis, as well as complications associated with the disease. All methods of treatment (including various forms of drug therapy) are considered. The disease is examined from the viewpoint of the problems faced by the practicing physician. The narration is by Paul H. Wehrle, M.D., Professor of Pediatrics, University of Southern California Medical School. This film won considerable accolade when premiered at the 1967 Clinical Meeting of the American Medical Association in Houston.

10:25 a.m. / Management of Incurable Breast Cancer

Through the courtesy of Lederle Laboratories, this film brings before the camera four highly qualified specialists in surgery, internal medicine, radiology, and oncology. The moderator (Dr. Joseph H. Farrow, Chief of the Breast Service at New York's Memorial Hospital) brings eleven typical composite cases of breast cancer before the panelists and seeks discussion from each on the methods of treatment. Dr. Gilbert H. Fletcher, of the Anderson Hospital in Houston, discusses radiologic treatment; Dr. Samuel G. Taylor, of Presbyterian-St. Luke's in Chicago, speaks on the use of hormonal therapy; Dr. Jeanne C. Bateman, of the George Washington School of Medicine in Washington, D. C., tells us about the use of chemical agents; and Dr. Henry T. Randall, of Memorial Hospital in New York, reports on the surgical approach.

11:15 a.m. / The Open Method of Burn Therapy

This presentation is through the courtesy of Eaton Laboratories. Here, the role of first aid and the advantages and technics of the open treatment of second and third degree burns are demonstrated. In the open treatment, burns are exposed to the air until healed or, in third degree burns, until ready for grafting. The closed dressing technic for areas not amenable to the exposure technic is also described. Skin grafting, with particular reference to stamp grafts is shown. Postoperative physiotherapy completes the demonstration.

11:35 a.m. / Confidence by Choice

Through the courtesy of Ortho Pharmaceutical Corporation, you will see a film which deals with current, medically accepted methods of conception control. It shows present technics in fitting diaphragms and the insertion of intrauterine devices. It portrays the use of foams and vaginal creams. The oral method is covered completely with a basic animated section discussing endocrinology. Contraindications to oral therapy are also given.

2:00 p.m. / Viruses and Cancer

Geigy Pharmaceuticals makes available this review of the etiology of cancer and, in particular, the possible role of viruses. This has been the subject of numerous studies dating back to 1908. After a half-century of dogged research, the question, "Is cancer due to a virus?", still cannot be answered categorically. This firm shows some of the major cornerstones in the research into the relationship between viruses and cancer. Today's research into the virus-cancer relationship in man is summarized and current hypotheses are discussed.

2:15 p.m. / Occlusive Arterial Disease

Through the courtesy of Ciba Pharmaceutical Company, you will see a clear demonstration of diagnostic procedures that can be conducted in the physician's office. Simple and important (and too frequently unused) diagnostic methods are demonstrated with a series of patients. This is an important reel because literally millions of aging patients are involved.

2:50 p.m. / The Role of the Endometrium in Conception and Menstruation

Through the courtesy of G. D. Searle and Company, a film here illustrates the current medical knowledge concerning the response of the uterus to stimulus by estrogen and progesterone in the normal menstrual cycle.

3:05 p.m. / The Man Who Didn't Walk

Through the courtesy of the Armed Forces Institute of Pathology Films, there will be presented a film examining complex medical and legal problems relating to traumatic psychoneurosis, exploring the difficulties which face a court of law in establishing the bona fide existence of this illness.

3:40 p.m. / Thyroid Deficiency—Current Concepts of Diagnosis and Treatment

Flint Laboratories, of Morton Grove, Illinois, recognizes that the exchange of ideas is the best and most efficient means to communicate vital information to an interested audience. Five physicians (each an expert in endocrinology) have come together to give you the benefit of their knowledge concerning hypothyroidism. The moderator for this really prime panel is Sidney H. Ingbar, Associate Professor of Medicine at Harvard and Chief of the Endocrine Division at Thorndyke Memorial Laboratory, Boston City Hospital.

1968 Annual Meeting

INFORMATIONAL EXHIBITS

Sunday May 19—1 to 5 p.m.

Monday and Tuesday, May 20 and 21
9 a.m. to 5 p.m.

Wednesday, May 22
9 a.m. to 12 noon

The Academy Of Medicine Of New Jersey

W. Franklin Keim, M.D., President, Bloomfield

Here is a graphic description of continuing medical education in New Jersey and its growth in recent years.

The Society For The Relief Of Widows And Orphans Of Medical Men Of New Jersey

James E. D. Gardam, M.D., President, and Joseph W. Gardam, M.D., Secretary, Belleville

For your interest, here is an informational exhibit outlining the aims and purposes of a truly eleemosynary organization which provides for the health and welfare of widows and orphans of deceased members of the Society.

New Jersey State Medical Assistants Association, Inc.

Shirley Palmer, Public Relations Chairman, Millville

Representatives of the Medical Assistants Association will distribute information concerning the organization. You will look over pamphlets which give the aims and purposes of the Association. The display includes pictures of the various county chapter activities throughout our state. Here too are brochures on the certification examination, both scientific and administrative. Also available is the "Plan Your Career as a Medical Assistant," pamphlet. It is our desire, this year, to arrange our booth to resemble an interior of a typical physician's office, with a desk, chairs, file cabinets and the like.

Bureau Of Children's Services

James B. Butler, M.D., Medical Consultant, New Jersey State Department of Institutions and Agencies, Trenton

Photographs are presented showing programs involving foster care, adoption, day care, protective services, group care, family counseling, and our seasonal assistant program. Pamphlets will be available for distribution.

X-Ray Collimation

William H. Aaroe, Chief, Radiological Health Program, New Jersey State Department of Health, Trenton

This exhibit emphasizes the general principal of x-ray exposure reduction by collimation to limit the x-ray beam to area of clinical interest. Chest radiography (14 by 17 inches) serves as the specific example of radiographic procedure depicted in the exhibit. Beams of light are used to simulate the paths of radiation and to demonstrate visually the area of body exposure that would result from the use of a rectangular cone limiting the beam to 14 by 17 inches and also from the use of cones providing beam diameters of 22 inches, 33 inches and 44 inches in sequence. Conclusion: 14 by 17 inches concentrates on "Area of Clinical" interest. The 22 inch beam diameter is useful because the gonads are outside of the direct beam. The 33 inch diameter means that gonads may be directly exposed. The 44 inch diameter indicates that the gonads are exposed to direct beam. The male gonadal dose is approximately 450 times that produced by 22 inch beam.

New Jersey Obstetrics Is Good

Bernard N. Millner, M.D., Chief, Maternal and Child Health Program, New Jersey State Department of Health, and Committee on Maternal and Infant Welfare, The Medical Society of New Jersey, Trenton

This three-panel exhibit indicates why New Jersey obstetrics is good. It reflects the tools used to improve it and shows how individual services can compare themselves with the State picture.

The Physician's Role In Youth Guidance

Charles B. Terhune, M.D., Committee on Youth, New Jersey Chapter, American Academy of Pediatrics, Summit

The role of the physician in anticipatory guidance will be presented with particular reference to discipline, sex education, and behavioral attitudes of early childhood. Practice aids (which are available for this sort of guidance) will be displayed. A list of sources of such material will be given to those who register.

The Carrier Clinic

Russell N. Carrier, M.D., President, and Robert S. Garber, M.D., Medical Director, Belle Mead

This exhibit will place a commercially constructed model of new and old buildings of The Carrier Clinic in the full view of members of The Medical Society. The new construction began in November 1967 and will be completed by November 1968. This will create an entirely new psychiatric facility incorporating new clinical laboratories, EEG, X-ray, admission suite, occupational-therapy and recreational-therapy facilities, dining room and kitchen. The new intensive care unit will have 200 beds. Also shown will be colored photographs of the interior.

Concepts Of Disability Evaluation

Jarvis M. Smith, M.D., Medical Director, and Eric Wolf, M.D., Assistant Medical Director, New Jersey Disability Determinations Service, Newark

Here is a display which describes the degree and process of disability, showing the "concept of disability" decisions under the Social Security Law.

A Report To Physicians On Regional Planning For Heart Disease, Cancer, And Stroke

Alvin A. Florin, M.D., Coordinator, New Jersey Regional Medical Program, National Institutes of Health, East Orange

This exhibit portrays the cooperative effort among the State's health institutions and organizations to bring to the citizens of New Jersey the latest advances in the diagnosis, treatment, and rehabilitation of heart disease, cancer, stroke, and related diseases. You will see how the planning process involves practitioners and administrators at the local level. This is aimed at one principal goal; that the physician in his office and in his community hospital can bring the benefits of clinical research and accomplishments to his patients.

Alcoholism Is Your Business

Council on Mental Health, The Medical Society of New Jersey, Trenton, and American Medical Association, Chicago

This exhibit points out that alcoholism is a disease and that it can be treated by a physician. The "center" contains a recorded telephone conversation between a distraught wife of an alcoholic and a physician.

Man's Exposure To Pesticides

Ray R. Kriner, Ph.D., Rutgers—The State University, New Brunswick, and Norman Plummer, M.D., New Jersey State Department of Health, Trenton

The purpose of this exhibit is to keep New Jersey physicians informed of the studies on pesticides being carried out in the State and in the country. Rutgers University now has a continuing study on the "Fate of Pesticides in the Environment." The State Health Department is carrying out a Community Study as part of a National Pesticide Program. This was organized by the Office of Pesticides of the National Communicable Disease Center. One primary purpose of this Public Health program is to determine the effects on human health of long-term exposure to pesticides.

In Honor Of A Rich Heritage

Martin H. Weinberg, M.D., Medical Director, Trenton State Hospital, Trenton

The historic roots of Trenton State Hospital are here presented on the occasion of the 120th anniversary of its founding by Dorothea Linde Dix. Among the articles to be displayed are: letters of Miss Dix and her writing case; a stool which belonged to the poet Robert Burns and given to Miss Dix during her travels in England; books from the original hospital library (Vesalius 1606; Harvey 1702; Browne 1672; Ruse 1812; Esquirol 1838); straight jacket and some electric machine used at the turn of the century for "nervous disorders;" patient commitment papers from 1848; needle work of Miss Dix; the original hospital seal; old photographs; and the famous portrait of Miss Dix. Pamphlets on Trenton State Hospital history will be available for distribution.

New Jersey Academy Of Ophthalmology And Otolaryngology

John Scillieri, M.D., Paterson

Shown here are cross section diagrams of the eye with explanation appended to each diagram. Transparencies will depict types of defects in vision. A good cross section of the ear with explanations on each side panel will describe diseases and defects of the ears.

Children's Specialized Hospital: The Rehabilitation Of Children

E. Milton Staub, M.D., Westfield

The aim of this exhibit is to show what services the Children's Specialized Hospital has available for children. These much needed services are not well known by the majority of the members of The Medical Society of New Jersey. Here are services which include nursing care, physical therapy, occupational therapy, recreational therapy, speech therapy, and education while hospitalized. The children's specialized hospital treats the orthopedically and neuromuscuarly handicapped as well as cardiac, metabolic, and congenital defect conditions.

Cancer Of The Skin: The Most Common And Most Preventable Cancer

Robert Hearn, American Cancer Society, New Jersey Division, Inc., Newark

The high incidence of skin cancer (now the leading cancer in this country in terms of the number of patients affected) and the great potential for prevention are presented. Ninety per cent of the cases of skin cancer are sun related. The nature and risk of actinic skin damage are explained and protective measures are described. The exhibit points out that while only about 5,000 deaths result annually from this disease, the mutilation and suffering which it causes could be greatly diminished through simple preventive measures, such as decreasing exposure to solar radiation by protective clothing and creams, and by early diagnosis and proper treatment.

Greater Delaware Valley Regional Medical Program

Barbara Whitmore Henry, Liaison Officer, Wynnewood, Pennsylvania

The Greater Delaware Valley Regional Medical Program has been established to develop cooperative relationships between practicing physicians, community hospitals, and health agencies of eastern Pennsylvania, southern New Jersey, and Delaware. Purpose of the program is to present an opportunity to the medical community to provide all patients of the region the benefit of the latest advances in the diagnosis and treatment of heart disease, cancer, stroke, and related diseases.

MESSAGE CENTER

courtesy of

New Jersey State Medical

Assistants Association

COFFEE LOUNGE

sponsored by

The Prudential Insurance

Company of America

1968 Annual Meeting

SCIENTIFIC EXHIBITS

Sunday May 19—1 to 5 p.m.

Monday and Tuesday, May 20 and 21
9 a.m. to 5 p.m.

Wednesday, May 22
9 a.m. to 12 noon

Highlights Of Surgery

Harold G. Scheie, M.D. and Jean E. Wolfe, B.S., University of Pennsylvania, Philadelphia

Technics for nine operations are shown in a series of color paintings and photographic slides as follows:

Cataract:

Intracapsular cataract extraction (Perpendicular corneal incision beneath corneal flap)

Intracapsular cataract extraction following filtering operations for glaucoma (Extraction superiorly through clear cornea)

Congenital Cataract:

Discission and aspiration of soft cataracts (congenital, traumatic, diabetic and others) in patients under 30 years of age.

Congenital Glaucoma:

Goniopuncture

Combined goniotomy and goniopuncture

Glaucoma:

Peripheral iridectomy with scleral gautery

Trephine without cornea splitting

Simple peripheral iridectomy for narrow angle glaucoma

Synechia:

Synechialysis

Surgical Correction Of Total Urinary Incontinence

Guy W. Leadbetter, Jr., M.D., and Donald B. Halverstadt, M.D., University of Vermont, Burlington, Vermont

This exhibit briefly outlines technics for correction of total urinary incontinence. Then you will see details of the technic which is the primary portion of the exhibit; and lastly you will see the results of this method for total urinary incontinence.

Pretibial Skin Defects: A New Technic In Management Utilizing Muscle Transplantation

Ralph Ger, M.D., Donald M. Pearlman, M.D., and Gershon Efron, M.D., Albert Einstein College of Medicine, New York

The tibia exposed by open wounds (operative or traumatic, with or without fracture, or as a result of chronic ulceration) presents us with a stubborn problem in treatment. The bone can be covered by muscles, mobilized for this purpose. These muscles are the soleus, flexor digitorum longus, and abductor hallucis. They may be used singly or in combination depending on the level of the lesion. A skin graft is then placed on the muscle. This exhibit illustrates the indications for, and technic of the operation. Selected case reports are presented. Overall results are here documented.

Reduction And Augmentation Mammoplasty

Robby Meijer, M.D., St. Barnabas Medical Center, Livingston

Correction of massive hypertrophy and ptosis of the breasts has many definite indications. The patients are relieved of a crippling condition after a relatively simple procedure. Complications are few. Augmentation of hypoplastic breasts is done more for psychological reasons. The Cronin prosthesis gives uniformly good results. Pre- and post-operative photographs are shown with steps of each procedure. Reduction as well as augmentation have much to offer patients with either hypertrophy or hypoplasia of the breasts.

Hydronephrosis In Irradiated Carcinoma Of The Cervix

Anthony R. Fernicola, M.D., St. James Hospital, Newark

This exhibit demonstrates the behavoir of hydronephrosis in patients irradiated for carcinoma of the cervix. X-ray evidence is presented to show spontaneous disappearance of hydronephrosis in these patients. The spontaneous regression on hydronephrosis is apparently the result of a reversible radiation ureteropathy heretofore unrecognized as a clinical entity. There is pointed out the differentiation between obstructive ureterecstasis and pyelecstasis which is irreversible and requires surgery and non-obstructive ureterecstasis and pyelecstasis which is reversible and non-surgical. These observations indicate that a decision to "buy time" can spare countless women the necessity of corrective major surgery for hydronephrosis.

Plastic And Reconstructive Surgery

William C. Conroy, M.D., Montclair, Edward N. Ludin, M.D., Camden, The New Jersey Society of Plastic and Reconstructive Surgery

This exhibit offers color-illustrated case presentations of common problems in plastic surgery.

Reconstructive Middle Ear Surgery

F. Robert Haase, M.D., and Julio T. Noguera, M.D., and William H. Petersen, M.A., Neptune City

Here is a pilot study of the Haase-Noguera prosthesis for reconstructive middle ear surgery. Sequential operative procedure will be shown in

medical drawings. Also exhibited will be various forms of the prosthesis and the results with each variation. In general, the use of the prosthesis has resulted in the creation of a viable middle ear space. It has led to an improvement of hearing to a socially adequate level in a high proportion of cases. However, variation in the prosthesis has indicated that some types have proved superior to others when long term hearing improvement is considered.

Lens Abnormalities In An Aging Population

A. A. Cinotti, M.D., J. C. Patti, M.D., and E. Tanne, New Jersey College of Medicine and Dentistry, Jersey City

Statistics are presented on the incidence of cataracts from birth to the age 90. Aso shown are figures on the incidence of various types of cataracts. Color transparencies are exhibited, taken by a new technic using a slit lamp and camera made by Zeiss. These transparencies demonstrate varied types of cataracts.

Radiofrequency Carotid Sinus Nerve Stimulation For Treatment Of Severe Hypertension

Theobald Reich, M.D., Alan F. Lyon, M.D., Julius Jacobson, M.D., and John Tuckman, M.D., New York University Medical Center and Mount Sinai Hospital, New York

Here, in graphic form, are clinical and physiologic effects of continuous radiofrequency carotid sinus nerve stimulation in a severely hypertensive man. A short history, medical findings, and clinical laboratory studies before and after implantation of the stimulators are shown. Various components of the stimulator will be demonstrated together with photographs of patients with implanted unit.

Leprosy Alert

Albert L. Rosenthal, M.D., and Thomas K. Rathmell, M.D., The Mercer Hospital, Trenton

As service men return from Viet Nam, the incidence of leprosy may well rise. Purpose of this exhibit is to alert our state's medical profession to the symptoms, signs, and diagnostic criteria of leprosy. The display will include three posters and an apparatus for the continuous projection of 2 by 2 Kodachrome slides.

Hemodialysis In Community Hospitals

Seymour Ribot, M.D., Martin Jacobs, M.D., and I. Richard Zucker, M.D., Newark Beth Israel Hospital, Newark

In this display, you will see what is done for in-hospital and home hemodialysis. The Newark Beth Israel Hospital began a chronic hemodialysis program January 1966. Thirteen patients with kidney failure (no longer amenable to medical treatment) were treated since the program started. Nine were trained for hemodialysis in the home and one was treated in the hospital pending renal homotransplantation elsewhere. The age, sex, diagnoses, and results will be shown in the exhibit. Surgical technics for arterial and venous cannulation are illustrated. The use of internal arterial-venous fistulae is also shown. Medical and mechanical problems are presented.

The Menopausal Patient: A Changing View Of The Change Of Life

Robert A. Wilson, M.D., Methodist Hospital, Brooklyn, and Wilson Research Foundation, Inc., New York

The rationale of hormone replacement in menopause is reviewed, with listings of effects attributable to estrogen/progestogen deficiency and photomicrographs of typical pre- and post-treatment vaginal cytograms. Practical patient-education programs are suggested, utilizing educational materials from the Wilson Research Foundation and the U.S. Public Health Service.

A New Operation For The Treatment Of Severe Reflux Esophagitis

Nicholas J. Demos, M.D., John DiBianco, M.D., and Joseph J. Timmes, M.D., New Jersey College of Medicine and Dentistry and B. S. Pollak Hospital for Chest Diseases, Jersey City

A new operation is here presented for severe cases of reflux esophagitis. Severe cases include (1) organic stricture, (2) stricture with short esophagus, (3) recurrent reflux, (4) post-esophagogastromyotomy, and (5) esophagogastrostomies. A viable myoneurovascular pedicle of a neighboring intercostal space is sutured around the esophagogastric junction. The advantages are: (1) it prevents reflux, (2) allows normal food passage, (3) has "sling action," (4) may be done at any level in the chest and on either side of the chest, (5) it is useful in recurrent cases, (6) it is simple and safe, and (7) it allows vomiting and eructation. Clinical cases and animal experimentations are presented.

Management Of The Multiple Sclerosis Patient

George J. Boines, M.D., Wilmington, Delaware

Multiple sclerosis, whether acute or chronic, mild or severe, recurrent or progressive, has a dismal prognosis. Complete medical management to provide ambulation, self-feeding, and independence in activities of daily living should be the objective of the physician who is treating the multiple sclerosis patient. By means of charts, graphs, diagrams, and case histories, the medical management of the multiple sclerosis patient is clearly delineated. Intrathecally injected methylprednisolone, as one aspect of the medical rehabilitation schedule, appears to be of benefit to these patients, probably through its local anti-inflammatory activity. The method of management and the results obtained in a series of 300 multiple sclerosis patients are demonstrated in the exhibit.

Routine Immunohistology As An Aid In Diagnosis And Treatment Of Renal Diseases

Kurt Lange, M.D., New York Medical College, Flower and Fifth Avenue Hospitals, New York

One hundred eighty-five kidney biopsies on patients with renal diseases were examined by the immunofluorscent technic for the presence of 7-S gamma globulin, complement and its components, and streptococcal endo-and exotoxins. All were also studied by a routine histologic review, and most of them by electronmicroscopy. This was compared with the clinical and laboratory results.

Acute glomerulonephritis was characterized by an intense diffuse homogenous staining of all basement membranes for gamma globulin and complement with no involvement of the mesangium. With healing, the immune-staining slowly disappeared, but much later than the usual clinical and laboratory findings.

Subacute glomerulonephritis showed uniform staining of all basement membranes for gamma globulin and complement. In addition, the widened mesangium was intensively involved in the immune process. Prolonged intermittent steroid therapy reduced or abolished the immune process as shown by rebiopsies.

Chronic glomerulonephritis revealed intense but only focal staining of some thickened basement membranes and their adjoining mesangium. Often only part of a glomerulus or even parts of a loop were involved.

A special form of nephrotic syndrome with uniform thickening of all basement membranes with marked diminution of cellular nuclei showed intensive uniform staining for gamma globulin and complement in a fine granular distribution within the basement membrane. Again massive steroid therapy seems to influence the immune process and the clinical course favorably.

Kidney biopsies in systemic lupus erythematosus revealed immune histologic pictures indistinguishable from different phases of chronic glomerulonephritis. Intensive treatment with glucocorticoids reduced or abolished the immune-staining.

In pure nephrosis, the basement membrane stained moderately and irregularly for gamma globulin and complement in all cases, while the nephrotic stage of chronic glomerulonephritis revealed the typical pictures of the latter disease. The influence of immuno-suppressive therapy will be demonstrated.

Three patients with a congenital nephrotic syndrome showed moderate staining of the basement membrane of many glomerular loops for gamma globulin and complement.

Immunohistology appears to be a valuable differential diagnostic and prognostic tool in renal diseases.

Posters and Kodachrome transparencies will illustrate the results.

Today's Problems Of Diuretic Therapy

Arthur Bernstein, M.D., and Melvin Odze, M.D., Newark Beth Israel Hospital, Newark

Diuretics are among the most commonly used therapeutic agents. What has increased the complexity of management has been the development of newer diuretics having special areas of utility and unique effects on electrolytes. This exhibit will present the mechanisms of action, the signs and symptoms and the management of situations such as potassium depletion, secondary hyperaldosteronism, dilutional hyponatremia and congestive heart failure with rising blood urea nitrogen. Problems of water and electrolyte depletion require better understanding and increased management considerations by the physician. These, too, are here reviewed.

A Gynecologic And Obstetric Quiz

James L. Breen, M.D., Herik Caterini, M.D., Jahir Sama, M.D., and Caterina Gregori, M.D., Newark City Hospital, Newark

This exhibit will present transparencies dealing with many phases of pathology as encountered in obstetrics and gynecology. The display will serve as a quiz, with appropriate histories being presented in a pamphlet, with an area for diagnosis. They will be graded and announcements made of diagnosis and winners.

Mesothelioma And Asbestos Exposure

Maxwell Borow, M.D., Sylvan E. Moolten, M.D., Alfred S. Conston, M.D., Lawrence L. Livornese, M.D., and Norbert Schalet, M.D., Middlesex General Hospital, New Brunswick, and Somerset Hospital, Somerville

Nineteen cases of mesothelioma were recognized within a three year period. All these patients had associated pulmonary asbestosis. Half of the mesotheliomas were pleural and the remainder peritoneal. Though most of these patients had occupational exposure to asbestos, several received their exposure through their environment. The clinical, radiographic and pathological features of both pleural and peritoneal mesothelioma are presented in this exhibit. The pathogenesis and relationship with pleural plaques are also discussed.

Coronary Cineangiography

Russell W. Brancato, M.D. and Nicholas A. Antonius, M.D., St. Michael Hospital, Newark

Purpose of this exhibit is twofold: to show the details of the performance of coronary angiography and indicate what information is gained from this diagnostic method. To be evaluated are (1) relative safety and risk of the procedure; (2) the clinical indication for its use; (3) ancillary studies which supplement arteriographic data; (4) to reflect what critical information can be obtained by this technic and (5) the place of surgery in the treatment of coronary artery disease.

Stress Tests And The Evaluation Of Anti-Anginal Drugs

Martin H. Wendkos, M.D., Veterans Administration Hospital, Coatesville, Pennsylvania

Three electrocardiographic parameters which depict characteristic nitrate effects have been selected to evaluate the effectiveness of four commonly prescribed nitrate compounds, in man. These have demonstrated that comparable doses of sublingual preparations of Glyceryl Trinitrate (GTN), Erythrityl Tetranitrate (ETN) and Isosorbide Dinitrate (ISDN) begin to act shortly after their administration, and that Isosorbide Dinitrate (ISDN) maintains its action signficantly longer than the other two. In the same manner, it has been shown that, perorally, only Isosorbide Dinitrate (ISDN) and Pentaerythritol Tetranitrate (PETN) consistently produced measurable cardiac effects; however, the onset of action of the former occurred appreciably earlier and its duration of action was considerably longer.

Neuroradiology in the Community Hospital

David L. Bloom, M.D., Richard J. Byrne, M.D., M. B. Ozonoff, M.D., Allan W. Newcomb, M.D. and Fred M. Palace, M.D., Morristown Memorial Hospital, Morristown

This exhibit is beamed at the general practitioner. Normal films also being paced in the exhibit so that easy comparison is available with the pathology at hand. The case will be one of meningioma accompanied by positive brain scan, positive angiogram, and appropriate history. An echoencephalogram is also included. The plain skull films if applicable would be shown as well. The second case will be an A-V malformation, the third, one of an infarct, and the fourth, of an aneurysm.

Tympanoplasty With Mastoidectomy: The Osteoplastic Method

i. M. Schnee, M.D., Barnert Memorial Hospital, Paterson

The exhibit includes enlarged illuminated transparencies depicting steps in an original procedure for removing pathologic tissue in chronic middle ear and mastoid disease with conservation of normal anatomic structures. The posterior wall of the external auditory canal (which is sacrificed in classical radical surgery for mastoid disease) is preserved by an osteoplastic flap shifting which provides exposure of tympanic structures. The bone is replaced, thus restoring normal anatomic relations and eliminating the creation of a mastoid bowl which requires lifetime care. Reconstruction of drum and hearing mechanism is performed in usual manner with fascia and prostheses.

Stereotaxic Surgery—Treatment of Parkinsons' Disease, Pain, Movement Disorders, Intractable Psychoses and Convulsive States

George A. Zazanis, M.D., and Henry R. Liss, M.D., Morristown Memorial Hospital, Morristown

Presented here is the Stereotaxic method of Spiegel-Wycis with the electronic equipment and stereoencephalotome. Stereoencephalotomy is a three dimensional precision type of surgery in which a needle electrode is placed with extreme accuracy into basal ganglia structures. The structures are stimulated with square wave current. Lesions are then made with direct anodal fractionated current. A sequential description of the method will be shown. Results of our own series of cases will be tabulated.

1968 Annual Meeting

TECHNICAL EXHIBITS

Sunday, May 19, 1968, 12:00 noon

Monday and Tuesday, May 20 and 21
9:00 a.m. to 5:00 p.m.

Wednesday, May 22
9:00 a.m. to 12:00 noon

Ortho Pharmaceutical Corp. #1

Ortho is proud to present the most complete line of medically accepted products for the control of conception. Of special note are the most recent products of Ortho Research Foundation, Ortho-Novum® 1mg tablets; Ortho-Novum® 2mg tablets; Ortho-Novum SQ® tablets, and Delfen® Cream and Foam. Also on display will be our well-known products for treatment of various forms of vaginitis.

Merck Sharp & Dohme #2

The Merck Sharp & Dohme exhibit has been designed to supplement the physician's therapeutic armamentarium. Technically trained personnel are available to discuss the scope and variety of services offered.

Lamond Products, Inc. #3

Lamond Dermatological Laboratories will introduce our newest product, Bur-Zin® (Burrows emulsion). This is a modified-Burrow's emulsion without lanolin. It is a companion product to Bur-Zin® emulsion which has been extremely well accepted in dermatologic practice as well as in other medical specialties. Lamond Products will be glad to discuss such popular products as Aquol® bath oil, the two Bur-Zin® emulsions, Bur-Cort,® Bentical® shake lotion, Dermasul,® Dermasorcin,® Dermastringe,® Sebana® shampoo, Sebanatar® shampoo, Lamotane,® and Sunprotectol.®

Blair and Company, Inc. #4

Information and consultation on specific investment programs tailored to the needs of the practicing physician.

South Jersey Surgical Supply Co. #5

South Jersey Surgical will feature Modular, the latest concept in physicians examining room furniture. They will also display three power driven examining tables, diagnostic instruments and carpeting for physicians offices.

Roche Laboratories #6

Continuing Roche research has produced outstanding contributions to medicine since 1909. The personnel at the exhibit welcome your comments, questions, or suggestions about our products and services.

Eli Lilly & Company #7

Summary not received

Winthrop Laboratories #8

The Winthrop Laboratories booth will feature the following: New Talwin® brand of Pentazocine (as lactate); Isuprel® (brand of isoproterenol) Mistometer; NegGram® (brand of nalidixic acid).

Mead Johnson Laboratories #9

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

The Coca-Cola Company #10

Ice cold Coca-Cola will be served through the courtesy and cooperation of the Coca-Cola Bottling Company of South Jersey, and The Coca-Cola Company.

Milex Products, Inc. Milex of Delaware Valley #11

Milestro,® a new specific for atrophic vaginitis, will be presented. Also reviewed will be developments in pelvic cancer detection and the Amino-Cerv,® specific for the post-operative cervix. The Milex Patient Level Sex Educational Series will be discussed.

Medical-Surgical Plan of New Jersey #12

Plan representatives will be present to answer your inquiries on the Prevailing Fee Program. Participation in this by all physicians is invited. Representatives will discuss any other matters relating to the Plan's policies, procedures, or payments. Opportunity for doctors to enroll as Participating Physicians in Blue Shield basic programs also will be extended.

Hospital Service Plan of New Jersey #13

Hospital Service Plan of New Jersey, the nation's pioneer Blue Cross Plan, provides more than 3,000,000 persons with the finest in prepaid hospital care protection. With nearly 250 contracting hospitals in New Jersey and adjacent states (and a link of over 6,000 other hospitals across the nation through the unique Inter-Plan Service Benefit Bank), Blue Cross makes available comprehensive service benefits for subscribers and their dependents.

U. S. Vitamin and Pharmaceutical Corp. #15

USV Pharmaceutical Corporation is proud to be at the 1968 Annual Meeting of The Medical Society of New Jersey. Our technically trained personnel are available to provide information on our new products.

The Upjohn Company #16

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research, designed to assist you in the practice of your profession. We solicit your inquiries and appreciate your comments.

Organon Inc. #17

The Hexadrol® (dexamethasone) family is presented: 0.50 mg., 0.75 mg. 1.5 mg. tablets combine highest quality with lowest patient cost; Hexadrol® Cream uses the efficient alcohol form of dexamethasone in 10 Gram and 30 Gram tubes, and Hexadrol Phosphate Injection® with 4 mg./cc in 5cc vials. Organon diagnostics for laboratory and office use, are also featured.

Janrus Recorders Corporation #18

Presented here are recorders for perfection in listening and recording audio tapes.

Our new Mercury and Aiwa Cassette recorders allow you to record lectures and conferences from a distance of over 40 feet. The recorders play or record stereo or mono up to 120 minutes on a single cartridge—standard type available anywhere.

We feature the following brand name recorders: Ampex, Uher, Crown, Mercury, Aiwa, Impex, Norelco, Sony.

Stiefel Laboratories, Inc. #19

Our representatives welcome the opportunity to discuss with you our line of dermatology specialties. Our acne products will be featured along with our highly absorbant microporous corn cob cellulose powder, Zeasorb.®

Abbott Laboratories #20

Abbott representatives will be pleased to present information and answer any of your questions relating to our broad line of hospital products and services and professional pharmaceuticals.

W. B. Saunders Company #21

New Saunders books published since last year's meeting include: Beattie and Economou: *Atlas of Advanced Surgical Techniques;* Williams: *Endocrinology;* Hamburger and Walsh: *Nephrology;* Trueta: *Studies in the Development and Decay of the Human Frame;* and Conn: *Current Therapy 1968.*

Lederle Laboratories #22

Lederle Laboratories is glad to be able to assist in the sponsorship of this meeting of The Medical Society of New Jersey. As one of the leaders in the research, development, and production of ethical brand-name pharmaceuticals, we present for your consideration products such as Declomycin,® Achromycin,® Aristocort,® Levoprome,® and others applicable to your practice. Our representatives have been trained to provide information on our products as well as on our numerous services to medicine.

Encyclopaedia Britannica, Inc. #24

Encyclopaedia Britannica welcomes delegates to tne 202nd Annual Meeting of The Medical Society of New Jersey. As part of the Encyclopaedia Britannica 200th Anniversary, we have on display the great new edition of Britannica, Great Books of the Western World, the Replica, Prespective, and so on. Stop and inspect these products. They are available to the delegates at our convention office.

Pro Services Inc. #25

Pro Services administers the Internal Revenue approved "trusted" Keogh Retirement Plan offered to the members of many county medical societies in New Jersey. The Plan offers a combination of fixed dollar investments with shares of Pro Fund, Inc., a "no-load" open end mutual fund, seeking growth of capital through increasing value of the securities in its investment portfolio.

Flint Laboratories, Division of Travenol Laboratories #26

Summary not received

Schering Corporation #28

Schering representatives will be available to discuss with you any questions you may have on Celestone® Soluspan® Injection, Tinactin,® Drixoral,® Afrin,® Etrafon,® Garamycin,® Valisone,® Gitaligin® or any other Schering product.

Syntex Laboratories, Inc. #29

Synalar® (fluocinolone acetonide), the topical corticosteroid designed to meet specific dermatologic needs, will be featured. Synalar® has set a new standard of success in the treatment of a wide range of inflammatory dermatoses. A warm invitation is extended to all physicians attending this meeting to visit our booth and discuss the latest developments from Syntex research.

A. H. Robins Company, Inc. #30

You are cordially invited to visit the Robins display and meet our representatives who will welcome the opportunity to discuss products of interest with you.

Sandoz Pharmaceuticals #31

Summary not received

Hoechst Pharmaceutical Co. #32

Our representatives will be happy to discuss Hoechst products with particular application to the physicians' individual practice. Featured is Lasix® furosemide.

Systemedics Inc. #33

Systemedics, Inc. offers medical office systems for billing, credit letter followup, and insurance form preparation. The Systemedics system virtually eliminates bookkeeping chores in the medical office. It provides accurate, detailed statements, insurance reports, and information for general management purposes. The entire operation can be handled by one individual, with a minimum of time and effort, with no equipment involved.

Astra Pharmaceutical Products, Inc. #36

Information and descriptive literature pertaining to Xylocaine® (lidocaine) and Citanest® (prilocaine), local and topical anesthetics, and iron preparations, Astrafer® (dextriferron) for intravenous use and Jectofer® (iron sorbitex) for intramuscular administration will be available at the Astra booth.

Siemens Medical of America, Inc. #37

Siemens Medical will display many advances in diagnostic and therapy equipment. Our representatives will be on hand to demonstrate our equipment and discuss practical applications with you. A few minutes at our booth will be time well spent.

The National Institute for Better Reading, Inc. #40

8 Roll Speed Reading Course with automated reading pacer and work book will be demonstrated to you and your colleagues.

Wallace Pharmaceuticals #41

Summary not received

Thomas A. Edison Industries Voicewriter Division #42

Summary not received

Dean Witter & Co. #43

Dean Witter & Co., Members of the New York Stock Exchange, is an investment banking and brokerage firm where human assets make the difference. Founded forty-four years ago, our organization has grown to 59 branches, from New York to Honolulu, including our newest office located at the Lord & Taylor Fashion Center, Paramus, New Jersey. At Dean Witter & Co., you'll find an inventory of complete facilities and servcies, where the emphasis is directed to the individual investor.

David and Charles Levinson #47

On display: Medco Products—*The Medcolator:* electrical muscle stimulator for relief of muscular pains, sprains, dislocations and other trauma of the muscle and skeletal system. *The Medco-Sonlator Twin:* A diagnostic and therapeutic instrument,

combining synchronized pulsed ultra sound with Medcolator current in continuous, pulse, surge and reciprocal settings. *The Medco-Therm:* An electronic instrument designed for simultaneous application of controlled moist infrared heat and electrical stimulation. *The Achilleometer:* An instant Achilles Reflex Test for testing thyroid function. Direct reading on an expanded scale, transistorized, battery operated. Quick-accurate-ready for instant use.

Parke, Davis & Company #48

Medical service members of our staff will be in attendance at the Parke-Davis booth to discuss two new products — Norlestrin 1 mg., an oral contraceptive and Ponstel® (mefenamic acid), an oral analgesic.

Cooper Laboratories, Inc. #49

Our representatives will be happy to answer any questions regarding our preparations. Featured will be Aveeno® Products, Quinaglute® Dura-Tabs, Ferronord,® and Ergomar.®

Ormont Drug & Chemical Co., Inc. #50

The Sterneedle® device provides a rapid, economical, painless method of screening a single patient or 450 per hour for tuberculin testing, vaccination, and allergy screening. Panjet®—a needle free method for painless jet injection for anesthesia, steroids, and so forth. This instrument represents a major breakthrough in medicine after many years of research and development.

Warren-Teed Pharmaceuticals Inc. #51

Featured Warren-Teed products will be Modane,® a nutritional deconstipant for rehabilitation and relief of the atonic bowel, and Kaon,® postassium therapy, well tolerated and rapidly absorbed in the gastro-inestinal tract (potassium gluconate in tablets and palatable elixir). Our representatives will welcome the opportunity to discuss these and other Warren-Teed specialty items with you.

E. & W. Blanksteen Agency, Inc. #52, #53

E. & W. Blanksteen have been official insurance brokers for The Medical Society of New Jersey since 1930 for the administration of officially approved plans of disability, major medical and life insurance. Information and literature, as well as personal consultation, are available at this booth.

New Jersey Bell Telephone Company #56, #57

Here you will see a demonstration of a new Bell System development providing for the instantaneous transmission of EKG data from a patient's bedside to a remote hospital laboratory or cardiologist's office, utilizing stationary or portable transmitter units. Shown, too, will be special communications aids developed for the physically handicapped, including equipment for patients with impaired speech and hearing.

Knoll Pharmaceutical Company #58

Akineton® is for Parkinson's drug-induced extrapyramidal disorders. Dilaudid® is for acute and chronic pain. Dilaudid® Cough Syrup is available for fatiguing non-productive cough. Metrazol,® Vita-Metrazol® and Nico-Metrazol® is used in treatment of geriatric patients for relief of symptoms of senility, apathy and chronic fatigue. Quadrinal® and Verequad® are for the relief of bronchospasm and wheezing. And this year, we introduce our new bronchodialtor/expectorant Theokin® Elixir for the symptomatic treatment of bronchial asthma, chronic bronchitis and pulmonary emphysema.

Endo Laboratories, Inc. #59

Endo Laboratories will present the latest clinical information relating to our products, Coumadin® (Sodium Warfarin), Percodan,® Valpin® (Anisotropine Methylbromide), Valpin® -PB (Anisotropine Methylbromide with phenobarbital).

Pfizer Laboratories #60

Displayed here will be Vibramycin,® Vistaril,® Diabinese,® and Urobiotic.®

Smith Kline & French Laboratories #64

Featured will be our comprehensive oral diuretic, Dyazide,® each capsule containing 50 mg. of Dyrenium® (brand of triamterent) and 25 mg. of hydrochlorothiazide.

The Emko Company #65

The Emko Company exhibits the first aerosol foam contraceptive. Emko Vaginal Foam has been professionally recommended for over seven years. It has a high level of effectiveness without side effects. Women appreciate its asthetic qualities. Stop at the Emko exhibit for samples and family planning booklets.

Geigy Pharmaceuticals #67

The Geigy exhibit features important new therapeutic developments in the management of cardiovascular disease as well as current concepts in the control of inflammation; hypertension and edema; depression; obesity, and other disorders, which may be discussed with representatives in attendance.

Ciba Pharmaceutical Company #68

Summary not received

Ayerst Laboratories #69

Summary not received

G. D. Searle & Co. #79

Our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be information on Ovulen-21,® Enovid,® Aldactazide,® Flagyl,® Lomotil,® Pro-Banthine® and other drugs of interest.

41st ANNUAL MEETING

Woman's Auxiliary to The Medical Society of New Jersey

Saturday through Tuesday
May 18, 19, 20, 21, 1968

Chalfonte-Haddon Hall
Atlantic City

Schedule of Events

Saturday, May 18, 1968

1:00 p.m. to 4:30 p.m.—Registration for Art Show
(Lobby floor, Haddon Hall)

*1:00 p.m.—Golden Merit Award Ceremony
(Rutland Room, First floor, Haddon Hall)

Sunday, May 19, 1968

9:30 a.m. to 4:30 p.m.—Registration
(Lobby floor, Haddon Hall)

10:00 a.m. to 4:30 p.m.—Sale of Tickets
(Lobby floor, Haddon Hall) for President's Luncheon—Monday
(Carolina Room, Chalfonte Hotel)
All doctors' wives invited

10:00 a.m.—Art Exhibit
—County Press and Publicity Books Exhibit
—County Activities Pictorial Display
(Lobby floor, Haddon Hall)

10:30 a.m.—Pre-convention Board Meeting
(Roberts Room, Office floor, Chalfonte)

12:30 p.m.—Fellowettes' Luncheon
(Blue Room, Office floor, Chalfonte)

2:30 p.m.—Tea and Fashion Show
(Rutland Room, First floor, Haddon Hall)

*4:00 p.m.—General Session—Address of Incoming MSNJ President
(Windsor Room, Haddon Hall)

*6:00 p.m.—Reception for President-elect Kustrup
(Pennsylvania Room, Haddon Hall)
Admission by badge

Monday, May 20, 1968

8:15 a.m. to 9:00 a.m.—Coffee and buns will be served
(Hallway, 13th floor, Haddon Hall)

8:15 a.m. to 4:30 p.m.—Registration
(Lobby floor, Haddon Hall)

9:00 a.m. to 12 noon—Tickets on sale
(Lobby floor, Haddon Hall) for President's Luncheon—Monday
(Carolina Room, Chalfonte Hotel)

9:00 a.m. to 12 noon—General Session
(West Room, 13th floor, Haddon Hall)

9:00 a.m. to 4:30 p.m.—Sale of Dinner-Dance tickets

12:30 p.m.—Annual President's Luncheon
(Carolina Room, Lounge floor, Chalfonte Hotel)

2:30 p.m.—General Session reconvenes

*7:00 p.m.—Dinner-Dance
(Pennsylvania Room, Haddon Hall)

Tuesday, May 21, 1968

8:00 a.m.—Breakfast for new county presidents
(Mandarin Room, 13th floor, Haddon Hall)

9:00 a.m. to 10:00 a.m.—Coffee and buns will be served
(Hallway, Tower floor, Haddon Hall)

9:00 a.m. to 12:00 noon—Registration
(Lobby floor, Haddon Hall)

10:00 a.m.—Post-convention Board Meeting
(West Room, 13th floor, Haddon Hall)

Convention Committee

Chairman—Mrs. Samuel J. Kaman

Co-Chairman—Mrs. John F. Perez

* MSNJ events to which the Auxiliary Members are cordially invited.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

February 18, 1968

A regular meeting of the Board of Trustees was held on February 18, 1968, at the Executive Offices. For your further information, detailed minutes are on file with the Secretary of your county society. A summary of the significant actions follows

Revision Of VA Fee Schedule . . . Referred to the Committee on Medicare (ODMC) a request from the New Jersey Neuropsychiatric Association that the current contract between MSNJ and the Veterans Administration relating to psychiatric fees and services to veterans be opened to review and readjustment.

Billing For Services Of Radiologist . . . Directed that the Radiological Society of New Jersey be advised (as a consequence of that Society's decision to request its members to bill Blue Cross directly — rather than the hospital — for services rendered) that while MSNJ has long been on record as supporting the principle of direct billing by physicians, in the present instance Blue Cross can compensate only hospitals and not physicians for services; thus direct billing by radiologists is not practicable or consonant with the terms of patient coverage.

Conference of Presidents . . . Authorized the scheduling of the spring conference of presidents and presidents-elect of component societies in conjunction with the March meeting, to be held at the Notre Dame High School in Trenton.

SMJAB Contract . . . Authorized the Secretary to sign the amended agreement with the State Medical Journal Advertising Bureau, empowering the Bureau's present advertising staff to affiliate with other personnel as "Medical Media Associates," incorporated in Illinois.

Council on Mental Health . . . Approved the following recommendation, subject to review by Legal Counsel before submission to the Publication Committee, and to considerations of cost and technical execution:

That the abstract of the Mental Health Laws compiled by Drs. Weinberg and Drake be submitted for publication in THE JOURNAL in the form of a removable center fold.

Workmen's Compensation . . . Approved the following recommendation from the Council on Medical Services. (By previous action of the Board of Trustees legal counsel had been directed to investigate repeated complaints of physicians that, under Workmen's Compensation, their fees were being arbitrarily reduced for services to state employees. The Council felt that the subsequent reply of legal counsel did not fulfill the directive.)

That the original recommendation of the Council (April 12, 1967) be resubmitted to the Board of Trustees; namely: that the Board of Trustees direct Legal Counsel to take up this matter directly with the office of the attorney general.

Title XIX . . . Approved the following recommendations pertaining to the Board of Public Welfare Recommendations Relating To A Title XIX Program In New Jersey (see page 120, March 1968 JOURNAL):

1. That provision be made to exclude chiropractors from inclusion under item 6, question 6.

2. That in relation to question 10, the Board of Trustees reaffirm MSNJ's policy decision that a Title XIX program "provide payment of physicians' services on the basis of usual and customary fees."

Legislation . . . Reviewed as amended the report of the Council on Legisation.

(All matters concerning current legislation will be included in the annual report of this council.)

Personnel Consultant Survey . . . Accepted the report submitted by Mr. William R. Monyer, personnel consultant, on a survey dealing with administrative and personnel assignments and operations of MSNJ, and referred it to the Special Committee on House Maintenance, Staff Policies, and Personnel Relations for implementation.

Liability Insurance . . . In response to a letter from the President of American Mutual Liability Insurance Company which expressed willingness to have his representatives discuss with the MSNJ Board of Trustees "any considerations it may have to warrant altering American Mutual's stated decision to write no new business and to retire from current policies at expiration on October 31, 1968," the Executive Committee, Dr. DeCecio, Legal Counsel, and the Executive Director are directed to meet with such representatives at the earliest possible time.

Emergency Medical Care . . . Approved the following recommendation pertaining to hospitals participating in the package disaster hospital and/or hospital reserve disaster inventory program:

That MSNJ recommend to the New Jersey Hospital Association that hospitals be encouraged to participate in sponsoring packaged disaster hospitals.

. . . Approved the following recommendation pertaining to medical self-help training programs:

(a) MSNJ encourage county auxiliaries to seek permission of their county medical societies to contact local superintendents of schools or district boards of education to elicit their cooperation in establishing the medical self-help program on an annual basis wherever it is not already in existence.

(b) The MSNJ Board of Trustees recommend to the component societies that they authorize their county auxiliaries to participate in this program.

. . . Approved the Committee's request that Dr. Samuel C. Ingraham, Director of the State Office of Emergency Medical Services be invited, as consultant, to all future meetings of the Committee.

Accessory Field Physicians . . . Approved the following recommendation from the Committee on Maternal and Infant Welfare as submitted by the Council on Public Health:

That the Department of Health engage, on a part-time basis, a qualified physician to serve as an accessory field physician to function in those counties where component societies have no physician dependably serving on a voluntary basis.

Board of Medical Examiners . . . Directed that the following nominations (to succeed the late F. Clyde Bowers, M.D. on the Board of Medical Examiners) be submitted in alphabetical order to the Governor:

Irving R. Hayman, M.D., Paterson
Joseph J. Kline, M.D., Trenton
Joseph A. Lepree, M.D., Elizabeth
Frederick C. Steller, M.D., Spring Lake

(This list is at the request of the Governor and is in addition to one submitted under date of May 24, 1967.)

1968 Annual Meeting Resolutions . . . Referred the following resolutions from the Union County Medical Society and from the Essex County Medical Society to the 1968 House of Delegates:

From Union County:

Inclusion of Physicians on Hospital Governing Boards . . . resolved, that MSNJ affirm its support of including a representative number of physicians on the governing boards of all New Jersey hospitals.

From Essex County:

Regulation of Hypnosis for Medical Purposes . . . resolved, that MSNJ actively seek legislation limiting hypnosis for the purpose of alleviating clinical symptoms to physicians and/or dentists licensed by the Board of Medical Examiners of New Jersey or a licensed clinical psychologist, and mandating certification of hypnotists qualified for medical purposes.

Bond Issue For Medical Schools . . . Directed that MSNJ go on record as urging support of a bond issue referendum in New Jersey for medical schools.

You Must Report Drug Users

Some physicians in New Jersey don't realize that narcotic taking is a reportable disease in our State. Here is part of 24:18-24.1 (Revised Statutes):

Report by physician of determination that person is suffering from effect of use of narcotic drug

Every physician shall, within twenty-four hours after determining that any person is suffering from the effect of the use of a narcotic drug as defined in section 24:18-2 of the Revised Statutes, taken for purposes other than the treatment of sickness or injury as prescribed or administered by a person duly authorized by law to treat sick and injured human beings, report such determination to the office of the Superintendent of the State police or mail a report thereof to that office.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of February:

	February 1968	Year To Date
Aseptic meningitis	4	8
Hepatitis – Total	109	256
Infectious and unknown	102	223
Serum	7	33
Malaria (servicemen)	11	20
Measles	58	92
Meningococcal meningitis	2	10
Mumps	618	1385
Primary and secondary syphilis	37	97
Salmonella	46	89
Shigella	5	13
German measles	208	244

Measles

Since a vaccine for German measles will probably be available within the next two years, your State Department of Health is making an effort to learn about the epidemiology of the disease so that vaccine recommendations can be made. To date, a study that has clarified much of the epidemiology of German measles was done by Brody* *et al.* They studied a rubella epidemic on an island in Alaska in 1963. Rubella had been absent for the previous 22 years from this isolated community of 400 inhabitants. A serologic survey showed that antibodies developed in 90 per cent of the susceptible population. Rash appeared in 40 to 90 per cent of susceptibles, with the highest rates among the 15 to 19 year-olds. Among susceptibles who did *not* develop rash, the majority had characteristic lymphadenopathy. There were no patients with rash among those over 22 years of age. 90 per cent of whom had pre-existing antibody. This alone would tend to indicate that immunity to rubella is solid.

One cannot say that the findings in an isolated Alaskan community are applicable to a New Jersey school population which is the group in which the disease appears in our state. Since German measles has become a reportable disease in several New Jersey municipalities, the Communicable Disease Control Program has been looking for situations where outbreaks may occur. Recently the first steps of such a study were taken in Freehold Township. Here are two elementary schools and one Junior High School. German measles began to appear in one of the elementary school populations during Christmas. During January, German measles were occurring only in this one school. When several cases appeared in the Junior High School with a population of 650, it was felt that there might about to be an outbreak. To determine the inapparent infection-to-case ratio, blood for antibody titers must be drawn before and after an outbreak. Since almost sixty cases had already occurred at the elementary school, we were too late to do the study there. The situation was discussed with school authorities and local physicians and on February 23 blood was drawn on 75 per cent of the Junior High School population. A surveillance system has been established to learn of future cases. If the suspected outbreak does occur, blood will be drawn before the end of school.

The Communicable Disease Control Program would like to study situations similar to this: i.e. evidence of German measles in one school with cases beginning at a nearby associated school.

Hepatitis

There were 1530 cases of hepatitis last year as opposed to 1092 cases during 1966. Of these cases, 87 per cent were classified as infectious hepatitis and the rest were either serum hepatitis or narcotic associated hepatitis. One-fifth of the cases of infectious hepatitis had a history of recent raw shell fish ingestion. Though the association of raw shell fish ingestion and hepatitis has been shown, one cannot assume an etiologic relationship from single cases.

The most striking change in the incidence of hepatitis during 1967 has been the increase in narcotic associated hepatitis. Reported

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* *JAMA* 191:8, February 22, 1965.

narcotic associated cases (which are probably markedly underestimated) rose from 84 to 151 cases. These are mainly in the 15 to 24 year-old age group. In some of the New Jersey cities for this same age group the incidence of hepatitis is 4, 5 or even 6 times the national average for this age group.

Inherit The Wind

"He that troubleth his own house shall inherit the wind . . ." and an evil wind it is! We have polluted our earthly home and "a foul and pestilent congregation of vapors" assails us.

Air pollution is a subtle enemy that has pervaded us insidiously. Our ignorance of its existence, its origin and its growth, permitted it to develop and spread unhampered. Enveloped in its miasmic embrace, we must now cast aside "a level of tolerance higher than good sense dictates." We must sharpen our awareness of pollution's sources, we must increase our understanding of its harm, we must enlarge our knowledge of means to control and abate it. May we eventually transmute it to a chimera!

Technicologic and legal means are at hand. Armed with enlightenment, we physicians have a significant part in achieving an environment compatible with health, in the fullest sense of that word. Our efforts must be directed to the benefit of the strong as well as the infirm, the resistant as well as the susceptible, the unborn generations as well as the present population.

A flight in a small plane at relatively low altitude permits a "breath-taking" view of the soiled streets and skies of the communities below—the co-mingling of emissions of industries generating plants, space heaters, automotive vehicles, and incinerators, with a soupçon of open burning. A trip on our expressways flanked by assorted spewing stacks makes our senses reel. It is evident that we have been perfunctory in our responsibility as guardians of the public's health.

We must function as a dual span of communication. It is our obligation to community health clearly to inform the people we serve of the destructive mental and physical effects of a critically deteriorating environment. This will develop a citizenry, alert to its personal responsibilities in maintaining a cleaner atmosphere and capable of recognizing, supporting, and demanding needed changes in land usage, fuel patterns, traffic plans, refuse disposal, and legislation and enforcement. We must also focus the attention of the architects of our world (the engineers, land planners, transportation experts, industrialists, and legislators) on the adverse physiologic effects of environmental contamination. We must point up the hazardous levels of exposures, the need to discover hitherto unidentified pollutants. To these ends we ourselves must be made acquainted with data from continuous monitoring of the air so that we know what we are inhaling.

The Air Pollution Division of the New Jersey State Health Department is in the forefront in this country in developing monitoring equipment. The number of areas thus monitored is still, however, inadequate. We physicians must gather long term and uniform records of our clinical and laboratory findings on our patients so that we can delineate the daily physiologic reactions to varying atmospheric changes. The most susceptible population will emerge from these studies and enable us to set the standards for permissible exposure levels to pollutants.

At public hearings on proposed controls, the physicians' voice has been pathetically still and small.

If you have not played your part in establishing a legacy of clean air, importune your County Society's Air Pollution Control Committee for guidance in taking the first step or write directly to the Air Pollution Control Committee of The Medical Society of New Jersey.

"Nothing to breathe but air. Quick as a flash, 'tis gone."

Roslyn Barbash, M.D., Chairman
Committee on Air Pollution Control

Award For Dr. Apgar

Each year the magazine, *Modern Medicine,* selects the ten physicians who have done the most that year for progress in our profession. In 1967, one of the winners was Virginia Apgar, M.D., a member of The Medical Society of New Jersey. Now, at age 58, she is director of research with the National Foundation. A 1933 alumna of Columbia University College of Physicians and Surgeons, she was cited by *Modern Medicine* for studies leading to the best practical method for rating the condition of newborn infants. "Because of Dr. Apgar — a crusading anesthesiologist (states the journal) — deficiencies in newborn babies are now better understood, and babies the world over have a much greater chance for normal birth and development."

Dr. Apgar points out that one-fourth of stillborn babies die during labor. The United States has a higher infant mortality rate than most industrialized nations. She feels that a new specialty — perinatology — is needed to assure proper care for the infant during labor and for two days after birth. In her present role, Dr. Apgar oversees dozens of National Foundation projects devoted to the hereditary and environmental causes of birth defects. She lectures in teratology at the Cornell University. She estimates that she has been present at about 17,000 births. In 1936, Dr. Apgar had become an assistant professor in anesthesiology at Columbia — the first woman physician in that specialty at P and S.

Dr. Apgar scored another "first" in 1949 when she became the first woman to attain full professorship at the medical school. While concentrating on obstetric anesthesia, she soon saw that little attention was paid to the new born infant. It was then that she developed her 10-point Apgar test, which, first presented in 1952, has now become a standard method for evaluating the condition of the newborn infant.

In 1959, Dr. Apgar received a master's degree in public health at Johns Hopkins University. She now predicts that two developments should lower the number of birth defects significantly in the near future: a vaccine for rubella which may be available by 1969, and research which seems to have solved the Rh-negative problem. For the long haul, she stresses the urgent need for more research on hundreds of unanswered questions about ovulation, labor, cell development, and chromosome aberrations.

Special Features of AMA-1968

Four general scientific meetings of wide medical interest are included in the program of the American Medical Association's Convention to be held in San Francisco June 16 to June 20. These sessions are:

1. *Automobile Accidents,* with participation by sections on Orthopedic Surgery, General Surgery, Pediatrics, Physical Medicine, and Preventive Medicine, as well as the AMA Committee on Medical Aspects of Automotive Safety.

2. *Health Care Planning,* with participation by sections on Preventive Medicine, Diseases of the Chest, General Practice, General Surgery, Internal Medicine, and Military Medicine.

3. *Management of Infectious Diseases,* with participation by sections on Experimental Medicine and Therapeutics, Allergy, Diseases of the Chest, General Surgery, Pediatrics, and Preventive Medicine.

4. *Treatment of Advanced Malignant Disease,* with participation by sections on General Surgery, Gastroenterology, General Practice, Internal Medicine, Nervous and Mental Diseases, Pathology and Physiology, Colon and Rectal Surgery, and Radiology.

Regular scientific agenda also will be presented by each of the 22 Scientific Sections, plus a Section on Miscellaneous Topics, which will include a session on smoking and another on neurologic surgery.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

DERMATOLOGY—Robert J. Carnathan, M.D., 1043 Fernwood Avenue, Maple Shade, New Jersey 08052. Georgetown 1962. Association with dermatologist, or multispecialty group. Available July 1968.

GENERAL—Loren T. Burns, M.D., 7 West 14th Street, New York 10011. University of Illinois, 1967. Available July 1968.

Lloyd O. Long, M.D., 337 East Main Street, Newark, Delaware 19711. Indiana University, 1963. Available.

INTERNAL MEDICINE—Harvey I. Hurwitz, M.D., 33 Coleman Road, West Haven, Connecticut 06516. Boston University, 1962. Group. Available July 1968.

Alfred M. Derrow, M.D., 555 Wisteria Way, San Rafael, California 94903. Tufts 1962. Subspecialty, Renal Disease. Group. Available July 1968.

Seymour M. Cohen, M.D., 1565-A White Drive, Rantour, Illinois 61866. University of Pittsburgh, 1962. Board eligible. Subspecialty, Hematology. Group or partnership. Available July 1968.

George G. Shashaty, M.D., 287 Linden Boulevard, Brooklyn, New York 11226. Georgetown University, 1962. Subspecialty, Hematology. Group or partnership. Available July 1968.

Harry M. Friedland, M.D., 2329 South Cedarbrook Road, Springfield, Missouri 65804. Downstate Medical Center (NYU), 1961. Subspecialty, Gastroenterology. Available July 1968.

Richard Kroner, M.D., 3750 Hudson Manor Terrace, Riverdale, New York 10463. New York Medical, 1964. Group. Available July 1968.

Edgar Lichstein, M.D., 1777-F Arlin Village Place, Fairborn, Ohio 45324. Downstate Medical Center (NYU), 1961. Board eligible. Subspecialty, cardiology. Available July 1968.

Kenneth Better, M.D., 512 North Lucas Drive, Fort Bragg, North Carolina 28307. Albany Medical College, 1961. Board eligible. Subspecialty, allergy. Group or associate. Available Fall 1968.

OBSTETRICS AND GYNECOLOGY — David M. Margulies, M.D. 69 Euclid Road, Fort Lee, New Jersey. Northwestern Universty, 1961. Board certified. Available.

Arthur G. Aneckstein, M.D., 104A Jupiter Street, Sheppard AFB, Texas 76311. Tulane, 1961. Board eligible. Solo, partnership, or association. Available.

Kenneth E. Bell, M.D., 3175 B Lexington Street, Hill Air Force Base, Utah 84401. University of Buffalo, 1961. Board certified. Available June 1968.

Jerry Goosenberg, M.D., 75-B Yorktown Drive, Fort Lee, Virginia 23801. Jefferson, 1962. Board certified. Group. Available July 1968.

Arnold J. Halpern, M.D., 516 Almond Court, Hampton, Virginia 23369. Jefferson, 1959. Board certified. Available June 1968.

Nicholas J. Criares, M.D., 8121-D Colorado Street, Wurtsmith A.F.B., Michigan 48753. St. Louis University, 1960. Board eligible. Group or associate. Available July 1968.

Lawrence N. Margolies, M.D., 12510A Turner Circle, Omaha, Nebraska 68123. Columbia 1962. Board eligible. Available July 1968.

OPHTHALMOLOGY—Harold J. Goldfarb, M.D., EENT Clinic, Womack Army Hospital, Fort Bragg, North Carolina 28307. Tufts, 1961. Board certified. Solo or associate in northern New Jersey. Available.

PATHOLOGY—Irvin D. Bough, M.D., 350 Lenox Road, Brooklyn, New York 11226. University of Santo Tomas, Manila, 1959. Board certified. Hospital. Available.

PEDIATRICS — James Sorger, M.D., 27 Warner Arms. Warner Robins, Georgia 31093, NYU Medical, 1963. Board eligible. Solo, group, partnership, or association. Available July 1968.

SURGERY — Dennis M. Wadler, M.D., 245 East 25th Street, New York 10010. Jefferson, 1961. Board eligible. Associate or group. Available July 1968.

Morton H. Goldstein, M.D., 3411 Wayne Avenue, Bronx, New York 10467. University of Chicago, 1959. Board certified. Plastic. Available summer 1968.

Martin Winick, M.D., 800 Victory Boulevard, Staten Island, New York, Downstate Medical Center (NYU), 1960. Board certified. Pediatric. Available July 1968.

Donald A. Sugar, M.D., 5 Wheeler Place, Fort Stewart, Georgia 31313. New York Medical, 1961. Board — part I. Group or solo. Available May 1968.

Robert Wegryn, M.D. St. Mary's Hospital, 89 Genesee Street, Rochester, New York 14611. Cornell, 1963. Board qualified. Group or partnership. Available August 1968.

UROLOGY—Alessandro Colalillo, M.D., 570 Mt. Prospect Avenue, Newark, New Jersey. University of Naples, Italy, 1955. Partnership or association with multispecialty group. Available.

Raymond D. Panetta, M.D., 632 Massachusetts Avenue, Riverside, California 92507. Georgetown, 1959. Board eligible. Group, partnership, or solo. Available June 1968

ANNOUNCEMENTS

Endocrinology Courses in Minnesota

The American College of Physicians announces a course in clinical endocrinology, April 22 to 26, at the Mayo Clinic in Rochester, Minnesota. The fee is $60 for ACP members and $100 for non-members. The course is designed to present material not readily available in standard texts on endocrinology, but which is essential to current understanding, diagnosis, and management of endocrine problems. Inquiries should be directed to the American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Advances in Coronary Disease

On Wednesday afternoon, May 29th, a symposium will be held at Red Bank, New Jersey, on "Therapeutic Advances in Coronary Disease." Sponsored by the Monmouth County Heart Association, the colloquium will be held at the Molly Pitcher Inn (Riverside Avenue). A distinguished and star-studded faculty will be the essayists and ample time is allowed for questions from the floor. For more details, write to Dr. Leonard S. Danzig, 27 Pinckney Road, Red Bank 07701.

Office Use Of Gyn-Cytology, Tutorial

Introduction is offered to the ten-second acridine orange-fluorescence method in the office application of cytology for: identification of trichomonas, monilia, bacteria, inflammatory cells, non-specific inflammations, estrogen and progesterone strengths, and introduction to normal and abnormal cells.

Open to only one physician at a time — 20 hours, preferably in one week. Evenings and week-ends available. Equipment is provided. Fee: $50. Write, Allan Lazar, M.D., 740 Carroll Place, Teaneck, New Jersey 07666. Phone: (201) 836-2070.

Thoracic Surgeons Organize

Announcement is made of the organization of a New Jersey Society of Thoracic Surgeons. President is Joseph J. Timmes, M.D. of Jersey City. Communications should be addressed to the Secretary-Treasurer, Franklyn P. Gerard, M.D. at 377 Roseville Ave., Newark 07107. The vice-president is Anthony D. Crecca, M.D. of Newark. The aim of the new organization is to assure a high level of cardiovascular surgical care to the people of New Jersey. A recent statement from the Executive Council of the New Jersey Society of Thoracic Surgeons is as follows:

"We take this opportunity to congratulate those pioneers who have made significant contributions to the transplantation problem. After years of laboratory application of well-known standard operative technics of heart transplantation, we, in New Jersey, are prepared for cardiac transplantation at this time.

"Each operation is another step toward the ultimate success of this procedure. However, there remain to be resolved many unknown factors, both moral and medical. These problems should be worked out in the sterility of the operating room and the solitude of the conference room and laboratory. Furthermore, we feel that "mechanical hearts" may well offer the broadest horizon in this challenging field."

First Aid Kit for Speaker

When it's time to deliver a speech, are you at a loss for words? Is your approach ineffective? Are you confronted with "delivery dilemma?" A possible solution to these typical problems is now provided by the Officers Services Department of the American Medical Association. An invaluable kit, *An Aid To Speakers,* may be the key to your individual success or to the success of your speakers' program. It contains a gold mine of source materials, ranging from interesting speeches beamed at lay audiences to numerous, up-to-date training tips. Physicians may obtain single copies free of charge by directing their requests to the Officers Services Department. Quantities of up to fifty are made availabe to state and county medical societies sponsoring formal speakers' programs.

LETTERS TO THE JOURNAL

Are We Making Hypochondriacs?

Dear Sir:

A few days ago I received in the mail twelve copies of an article from the January 1968 issue of Reader's Digest entitled, "What the Cigarette Commercials Don't Show," a horrifying description of the postoperative condition of patients after radical surgery for malignancies of the mouth, tongue, throat, larynx, etc., recited by one such patient. This is about as ghastly reading as I have seen in many a day. (I ceased smoking some years ago.) As shown by the boxed-in message printed at the conclusion of this article, these reprints came from the Chief, Cancer Control Program, USPHS, exhorting me to heed the warning of the article, as it could save my life; and then to pass it on to a friend.

I feel certain all doctors will agree that we have far too many emotionally and mentally disturbed folk in our society for us to hazard an increase in their number by distributing such a frightening story among cigarette smokers who, if they continued the habit 'till now, reveal a lack of motivation, or willpower, to terminate it — and so are apprehensive already.

So I ask: is the possible prevention of one or two cancers, at a cost of serious emotional or mental breakdown in many folk by distribution of articles like this one, a justifiable trauma to our citizenry, and is it not reprehensible that such distribution be sponsored officially by the very Service which is supposed to promote the public welfare?

Lastly, does it not seem wise that, hereafter, releases by the Cancer Control Program of the USPHS be submitted to a Staff psychiatrist for approval before mailing, and did the magazines which printed this article, or any similarly horrendous recitals, do a commendable service to their readers?

Albert G. Hulett, M.D.
17 February 1968 Orange, New Jersey

Editorial comment on this matter appears on page 136 of this issue.

Semantics Of The Waiting Room

Some months ago, your editor suggested that the phrase, "waiting room" gives the impression of a static wait, and maybe something pleasantly positive like "reception room" would be better. Of course, the replacement of a good Anglo-Saxon word like "waiting" with something elegantly French like "reception" always opens the door to the proponents of Anglo-Saxon words — not just the four letter ones. Anyway, we here publish Dr. Geib's pleasant letter. And your editor doesn't know whether to say something learnedly Latin like *mea culpa* or *gaudeamus igitur,* or just to plead the fifth amendment and let it go at that. Anyway, imprimatur! H.A.D.

Dear Doctor Davidson:

Why stop at Reception Room? "Examining Room" is just as bad as "Waiting Room:" examining, exams, cramming, cribbing, flunking! Horrors!

"Laboratory" is OK; everybody knows that laboratories are splendid places where miracles are performed. "Ladies" and "Gentlemen" might just pass, but what if you have only one? "Consulting Room" sounds too much like "insulting" to be acceptable.

I imagine the patient waiting upon the gracious hostess in the Reception Room and being conducted to the Hospitality Corner where he leaves his (credit) cards, and is regaled with a light collation.

After he has passed a few moments perusing his preferred selection from a copious variety of cultural literature, he will be begged (or prayed) to step into the Study Centre, where an exhaustive enquiry will be made into his curriculum vitae. From thence he will be escorted to the Retiring Room. After divesting himself of his garments, he will ambulate to the adjacent Scrutiny Space, where the basis of his discomforture will be attempted

to be clearly elucidated. Should the occasion arise, he may privately sequester himself in the Relieving Room.

Clothed and in his right mind, he participates in a recapitulation session where suitable measures to be implemented for his amelioration are reviewed. He then makes his departure by the Egress, not failing to pause and render unto Caesar.

I hope you are wakened every night by the ghost of Fowler sitting on your chest and intoning: "Love of the Long Word, Wardour Street, Periphrasis, Working and Stylish Words, Battered Ornaments, Genteelisms!"

I have the honour to remain, sir,
Your humble servant,
M. Eugenia Geib, M.D.
Morristown, New Jersey

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1968
April

9 **Bergen County Medical Society**

9 **Cumberland County Medical Society**

9 **The Academy of Medicine of New Jersey**
Newton Memorial Hospital, Newton
"Problems of Oral Contraceptives"

9 **The Academy of Medicine of New Jersey — Section on Radiology**
Veterans Administration Hospital
East Orange
Presentation of Interesting Radiologic Cases of the Genito-Urinary Tract

9 **The Academy of Medicine of New Jersey — Section on Dermatology**
"Special Surgical Technics for the Dermatologist"

10 **Ocean County Medical Society**

10 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Biochemical Pharmacology And The Brain"

10 **Gloucester County Tuberculosis and Health Association**

12 **Cooper Hospital**
Camden
"What's New in Dermatology?"

15 **St. Barnabas Medical Center**
Livingston
Conference: "Complications of Regional Anesthetic Agents and Technics"

16 **Warren County Medical Society**

17 **Middlesex County Medical Society**

17 **Newark Beth Israel Hospital**
Newark
"Mechanics and Management of Cardiogenic Shock"

17 **Middlesex General Hospital**
New Brunswick
Symposium: "Problems in Management of Premalignant and Malignant Tumors of the Uterus"

18 **Morris County Medical Society**

18 **Gloucester County Medical Society**

19 **Cooper Hospital**
Camden
"Chromosome Aberration in Old Age and Malignancy"

24 **The Academy of Medicine of New Jersey**
Veterans Administration Hospital
East Orange
Dental Symposium: "Clinical Periodontics — Recent Advances"

26 **Cooper Hospital**
Camden
"Immunity—Its Role in Health and Disease"

30 to May 3 **Atlantic City Hospital**
Visiting Chief Program
Nathan S. Schlezinger, M.D., Professor of Clinical Neurology, Jefferson Medical College, Philadelphia

May

1 **Camden County Medical Society**

1 **The Academy of Medicine of New Jersey with American Cancer Society (New Jersey Division)**
Trenton County Club
Symposium: "Cancer of Colon and Rectum"

1 **Passaic County Heart Association**
Symposium on New Concepts in Cardio-Vascular Disease

7 **Hudson County Medical Society**
Election of Officers

8 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Drugs, Poisons, and Membrane Phenomena"

8 **Ocean County Medical Society**

8 **Gloucester County Tuberculosis and Health Association**

8 **Middlesex County Medical Society**

9 **Essex County Medical Society**

14 **Bergen County Medical Society**

16 **The Academy of Medicine of New Jersey — Section on Radiology**
Newark City Hospital
Radiologic Cases

16 **Morris County Medical Society**

16 **Gloucester County Medical Society**

18-22 **The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Annual Meeting

19 **The Academy of Medicine of New Jersey and The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Symposium on Medicine and Religion

20 **St. Barnabas Medical Center**
Livingston
Conference: "'Local Anesthetics — Old Drugs With New Uses"

21 **The Academy of Medicine of New Jersey**
Newcomb Hospital, Vineland
Symposium: "Therapy of Lymphomas"

28 **Cape May County Medical Society**

29 **Monmouth County Heart Assoc.**
Molly Pitcher Inn, Riverside
Symposium: "Therapeutic Advances in Coronary Heart Disease"

June

6-7 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Culdoscopy

11 **Ocean County Medical Society**

11 **Bergen County Medical Society**

11 **Cumberland County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"The Thymus — Its Role in Immunity and Disease"

18 **Warren County Medical Society**

20 **Morris County Medical Society**

Survey on Venereal Disease

On July 1, 1968, you will receive a questionnaire asking the number of cases of syphilis and gonorrhea treated by you from April 1 through June 30, 1968. This national survey of VD incidence is a repeat of a similar 1962 poll and is sponsored jointly by the American Medical Association, the American Osteopathic Association, the National Medical Association, and the American Social Health Association in cooperation with the Public Health Service.

VD is infecting Americans at the alarming rate of a million new cases a year and is now the nation's most urgent communicable disease problem. Private physician reporting has increased considerably since the 1962 survey, which showed the level of reporting to be only 11 per cent of the infectious cases treated. The 1968 survey should determine the extent of the increase.

The questionnaire card requires no signature and replies of individual physicians will *not* be identified by name. Results of the survey will be published nationally by the sponsoring organizations. Please cooperate.

OBITUARIES

Dr. Joseph F. Barrett

One of Maplewood's best known physicians, Dr. Joseph F. Barrett, died on January 28, 1968. Dr. Barrett was on the staff of St. Barnabas Medical Center in Livingston. He served as a major in the medical corps of the Army of the United States from 1942 to 1945. Born in 1899, he received his M.D. at the University of Virginia in 1928.

Dr. Howard F. Brock

On the third day of the new year, death came to Howard F. Brock, M.D., a senior (79 year-old) member of our Union County Medical Society. Dr. Brock worked in Westfield and was proud to be known as a general practitioner and family doctor. He was an authority on school medicine and school health problems. Dr. Brock was in the class of 1914 at the medical school of Howard University.

Dr. Raphael S. Cantini

At the age of 67, Dr. Raphael Cantini, a prominent Plainfield urologic surgeon, died unexpectedly on February 14, 1968. Born in 1901, Dr. Cantini was a 1926 graduate of Boston Medical College and, after a brief period of general practice, became interested in urologic surgery. He became a Board Diplomate in that specialty, and chief of that division at the Muhlenberg Hospital. He was also affiliated with the John E. Runnells Hospital and other institutions in the Union County area. Dr. Cantini was a consultant at the Veterans Administration Hospital at Lyons. He was a member of the New Jersey Society of Surgeons, and a Fellow of the American College of Surgeons.

Dr. Lester F. Meloney

Listed in *Who's Who in World Medicine* as a prominent public health physicians, Dr. Lester Meloney died on September 8, 1967. He was, for many years, the health officer of Clifton, New Jersey, and was active in the work of the American Public Health Association. Dr. Meloney was a graduate of the College of Physicians and Surgeons (Columbia University) in 1905.

Dr. Rocco M. Nittoli

Doctors are frequently urged to take more active roles in civic affairs. One physician who never needed this admonition was Rocco M. Nittoli, M.D., who died on February 16, 1968, at the age of 74. He was born in Newark but lived most of his life in Elizabeth. His M.D. came from Jefferson in 1916, and a year later he was commissioned in the medical corps of the Army of the United States. He rose from lieutenant to major and received the French Medal of Honor for his services in World War I.

Dr. Nittoli served as president of the Union County Medical Society, of the Elizabeth Board of Education, of the "Regular Fellows of Elizabeth," of the medical division of his city's Civil Defense Corps, of the Elizabeth Health, Welfare and Housing Office, of the Italian-American Civic League, of our state's Society of Surgeons, of the Military Order of Foreign Wars, of the Elizabeth Board of Health, and so on, in an almost limitless list of civic enterprises. He was a laureate of the Elizabeth Teachers' Association which, in 1955, presented him with the Distinguished Service Award for his efforts to improve public education.

He served on the surgical service of all three Elizabeth hospitals, and was a Fellow of the American College of Surgeons.

Dr. Andrew J. Oberlander

The senior medical director of the country's largest insurance company—Dr. Andrew J. Oberlander of the Prudential—died on New Years' Day 1968. Born in 1905, he earned his M.D. at the medical school of Yale University in 1933. Always interested in, and active in, administrative and rehabilitative aspects of medicine, he won a place on Prudential's medical staff early in his career and eventually became the medical director of the entire program. He was active in the affairs of the Essex County Medical Society.

Dr. George Randall

As most of us would like to, Dr. George Randall died with his boots on. He was examining a patient on March 2, 1968 when the fatal attack seized him. He was only 54 at the time of his death. Dr. Randall was a 1942 graduate of the medical school at Temple University in Philadelphia. He became one of the dwindling group of family doctors and was affiliated with the Valley Hospital in Ridgewood. Dr. Randall was active in the affairs of the American Academy of General Practice. From 1943 through 1946, he was a captain in the medical corps of the Army of the United States.

Dr. Ralph B. Thomas

On February 27, 1968, a full and rich life came to a close with the death that day of Ralph B. Thomas, M.D. at the age of 82. Dr. Thomas was a pioneer in ear-nose-throat, entering the field when ophthalmology was still combined with otolaryngology. Born in Canada in 1887, he received his M.D. at the University of Vermont in 1909. He opened his office in Jersey City in 1912, and interrupted practice to enter the Army of the United States in 1917. He was, from the beginning, identified with most of the hospitals in Hudson County. In 1953, at the age of 66, he moved to the New Jersey Shore and worked in Eatontown and Long Branch for another decade.

Dr. Clifford G. Weston

One of the area's pioneer allergists, Dr. Clifford G. Weston, died on December 20, 1967 at the age of 75. An early member of the American College of Allergists, he was the senior consulting allergist at both the Mountainside and Newton Memorial Hospitals. Dr. Weston received his M.D. at Columbia University's College of Physicians and Surgeons in 1918.

BOOK REVIEWS

Diabetes Mellitus: Diagnosis and Treatment, Vol. II. New York, 1967, American Diabetes Association, Inc. Pp. 250. ($2.50)

This volume represents part of the educational program of the American Diabetes Association for its members and other doctors. The care with which the editors have constructed it could serve as a model for other subspecialty publications. Recent literature is woven into the text in an understandable form in spite of some of the complexities of the original presentations. The new material is admirably related to an orderly total concept of the physiology, diagnosis and treatment of diabetes mellitus. Related errors of carbohydrate metabolism are well discussed with special reference to differential diagnosis.

The newer ideas of abnormal insulin metabolism, brittle diabetes, and insulin resistance are well reviewed. Alexander Marble's "Common Errors . . ." chapter and Richard Field's summary of the present data on hypophysectomy for diabetic retinitis are highlights of conciseness and useful clinical approach. Danowski contributes an excellent discussion of the lately discovered syndromes of nonketoacidotic comas using his text to differentiate the various types of hypoglycemic comas as well lactic acidosis and hyperosmolar comas.

In a field with such rapidly changing concepts, no volume can do more than give the current thought, maintaining at the same time an anticipatory attitude of imminent changes. The authors of both this and the first volume have succeeded in that objective, and given a solid guide as well for a practical clinical approach.

EVERETT O. BAUMAN, M.D.

Atlas of Glaucoma Surgery. John N. McLean, M.D. St. Louis, 1967, Mosby. ($17.50). Pp. 126 with 88 figures prepared by Shirley Batty.

This atlas is not just another book about glaucoma. In this small volume John McLean illustrates his own personal technics relating to the surgical management of this common disease. I was impressed by the balance created by a concise and lucid text and simple, clear diagrams. No attempt is made to compress several small illustrations on one page, as is seen in too many atlases. Here the diagrams are almost always directly opposite the text relating to them, so no unnecessary leafing of pages is required.

Although Dr. McLean stresses his own ideas, he also mentions alternate methods with a critique of their advantages and disadvantages.

The section dealing with surgery for infantile glaucoma is one of the most lucid presentations that this reviewer has seen in any book. That this atlas is current is well reflected by the text and by the sketch showing the method for cyclocryothermy.

This excellent atlas will be an invaluable addition to our surgical armamentarium. I recommend it to all who treat patients with glaucoma.

BERNARD SUSSKIND, M.D.

The Unquiet Mind. William Sargant, M.D., D.P.M., Boston, 1967, Little, Brown. Pp. 232 ($5.95)

Some emotional disorders are caused by biochemical or structural changes and some are precipitated (and, possibly caused) by emotional experiences. That is so obvious that one wonders why this truism has become a battlefield. Yet the arena resounds with epithets as the adherents of essentially emotional explanation (especially psychologists) dub the organically oriented M.D. as a "mere urine boiler." And the urine boilers hurl their own pejorations at those who offer symbolic or "psychodynamic" explanations for anxiety or depression. Dr. Sargant is definitely in the "organic" camp, and makes cheerful claims here for the effectiveness of shock, drugs, or lobotomy.

Here are some examples of this buoyant optimism. Describing medication, he tells us that "84 per cent of patients with schizophrenia . . . were discharged after only six weeks treatment and found to be relatively well and happy. No psychotherapy beyond a few common-sense talks were needed to obtain these results." Again, "Nowadays we need only to prescribe five electric shock treatments or some new antidepressant drugs, whereupon the patient is himself again without any need for an elaborate case history." Describing "Largactil" (British for chlorpromazine), he writes that "Largactil really deserves the name of the 'wonder drug'." He is happy with lobotomy, too, explaining that its "beneficial effects can be obtained in all suitable patients." Here, the operating adjective is "suitable." Sargant has had good results not only with psychotics but also with psychoneurotics: "Patients who had been ill for 20 years with phobias of travelling, closed spaces, even going out of the house, suddenly started to get better with Nardil, Marplan, Parnate and the like."

Sargent feels that those who stress organic factors are, in a sense, being persecuted by the more analytically oriented. He says that the activities of his colleagues and himself in Britain "might well be counted against us because we were not going to be subservient to the psychiatric bureaucracy." Similarly, he feels that Meduna, a pioneer in shock treatment "was ridiculed and forced to emigrate" and that Walter Freeman "was cut by his colleagues because of his advocacy of leucotomy."

Curiously enough, Sargant describes symptoms in himself which most of us would have to call psychosomatic. Angry at being denied recognition for his pioneering subinsulin work, he says: "They made me so furious that a physical pain shot through my chest!" The author insists that this was a *physical* pain, though he ascribes it to his emotional state. The next day "repressed anger at something else caused the same acute pain which was succeeded by influenza with a temperature." (He probably meant a fever).

Of course psychiatric practice in Britain *is* different in some respects from practice in the U.S.A. In our country, the large public mental hospitals too seldom attract top-notch psychiatrists and we know why. But in Britain, as the author says, "It is fortunate that our mental hospitals contain so many of the country's leading psychiatrists."

The book is graced by a brief and stimulating preface by the late and affectionately remembered Ewen Cameron. Cameron suggests that "men like Sargant with their willingness to challenge authority and dogma to bring in new methods . . . have earned the gratitude of their fellow men." And indeed, whatever else one may say about the life here portrayed, it certainly was, in Cameron's phrase, lived "with the joy and zest for life."

HENRY A. DAVIDSON, M.D.

Expanding Theory and Practice in Family Therapy. Edited by Nathan W. Ackerman, Frances L. Beatman, and Sanford N. Sherman. New York, 1967, Family Service Association of America. Pp. 182 ($5.00)

In this slim but interesting and stimulating volume are the views and experiences of fourteen scientists who here contribute to the better understanding of the problems of family therapy. Naturally, the clarity of the presentation depends on the individual writer's style. The volume is certainly not a primer or even a basic text for a neophyte. But as a comprehensive survey of present-day theory and practice of family therapy, it will be of definite help to the reader who has some preliminary knowledge of the subject. The text tries to explain what a "family" is in terms of a "single organism" versus a "process." Outstanding is Brodey's contribution in his description of a few family types. Although concise, his description is accurate and illustrative. Also, "non-transferences" are well elucidated here. In my judgment, the best chapter is the one by Ackerman which presents a family therapy session verbatim with some interpretative comments. It is regrettable, that due to mechanical failure, Brodey's interview could not be included in this book.

"Live" supervision so aptly and interestingly presented here by Kempster and Savitsky is, as they say, "painful" to the therapist. Yet, we know of no better method of teaching at the present. Guidance via this method is truly authoritative and helpful even if (initially at least) embarassing at times.

Every chapter in this volume contributes to a better understanding of family therapy, each in a different way, and each is a link in the vast chain of elements contributing to this therapeutic approach.

This book is highly recommended to all who (a) do work in this fascinating area, and (b) to those who wish to know more about it in order to start working wth family groups. This volume also shows how much has been done so far, and how very much must still be understood to refine our efforts, and to make greater contributions to the communication patterns as they arise in this type of therapy.

KENNETH K. BERMAN, M.D.

Drugs of Choice 1968-9. Edited by Walter Modell, M.D. St. Louis, 1968, Mosby. Pp. 907. With 45 contributing authors. ($17.75)

As Dr. Modell says in his introduction, recent activity in the Food and Drug Administration, has shifted to the physician "the responsibility of a patient's adverse drug reactions." This underlines the need for an authoritative reference work with emphasis on side-effects, dosage limitations, and contra-indications. Some pharmacology texts are written by laboratory scientists, but in this book, the contributors are practitioners who have actually prescribed the medications they recommend and seen at the bedside the good and bad results.

The work is divided into chapters covering the clinical modalities — such as diuretics, antiseptics, anorexiants, or into therapeutic groupings such as drugs for intestinal parasitism, or drugs for hypertension and the like. There is an every-day useful appendix on green paper which lists trade names and tells what each drug is, and which gives information about dosage and dosage forms. Also included is material on the legal problems in prescribing drugs, on the principles which should guide the clinician in selecting a medication, a section on the treatment of poisoning (including a unique guide on what you should have in a poison-control bag), and some 49 tabulations of quick reference therapeutic information. In various editions, *Drugs of Choice* has been around since 1958 and its complete acceptability by the profession indicates that the editors must be doing something right. Each chapter is by an experienced practitioner who tells us what drugs *he* chooses and why. The pros and cons of controversey are referred to, but the reader is not left confused by a text which says yes, and then again maybe not. This book will soon earn its keep on any physician's book shelf.

VICTOR HUBERMAN, M.D.

Patients, Doctors and Families. Faye C. Lewis, M.D. New York, 1968, Doubleday. Pp. 140. ($4.95)

This slim volume discusses in a very chatty way many aspects of the general practice of medicine. The book was written primarily for patients, the sub-title being, "A book to help you understand sickness and your doctor." But it should prove interesting to those considering the practice of medicine as a career.

Faye C. Lewis shares with her readers many experiences as shown by some of these chapter headings: The Problems and Pleasures of Old Age; Marytrdom and the Demanding Parent; Fears: Real and Imaginary; A Special Kind of Grief: The Death of a Loved One; The Doctor and His Ethics.

A reflection of her philosophy which prevades the book is found on page 122. "Preserving one's health should be a means to an end, not the end itself, and I think this should be stressed more than it is in health promotional literature. Not 'keep yourself of some use on earth as long as possible.' The latter goal connotes a reasonable amount of attention to the former, of course, but the purpose in view is a much more noble and satisfying one. Nor is physical fitness always a reliable measure of usefulness. I have known a number of instances in which a frail, ill, crippled, or otherwise handicapped member of a family was its center of emotional strength and solidarity."

I enjoyed reading this book, as many of your patients might. Its brief chapters could provide interesting, light reading for your waiting room.

LAURA E. MORROW, M.D.

Hematology: Laboratory Medicine. John B. Miale, M.D. (3rd Edition) St. Louis, 1967, Mosby. Pp. 1257. 565 illustrations. ($21)

For a decade now, Miale's *Hematology* has been a standard reference work in the field. This current edition has more detail than previous editions offered about the hemoglobinopathies, has an enlarged section on the leukemias, introduces new thinking on the lymphomata, and has a rewritten chapter on immunoglobulin abnormalities. All blood elements are studied, and all diseases of the blood are presented. The 100-page appendix constitutes a veritable and practical manual of laboratory methods and technics in the field of hematology. All in all, this is a solid, satisfying, authoritative, and highly readable work that will soon earn its keep in any laboratory.

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(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology *89*:438-443 (Sept.) 1967.

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about

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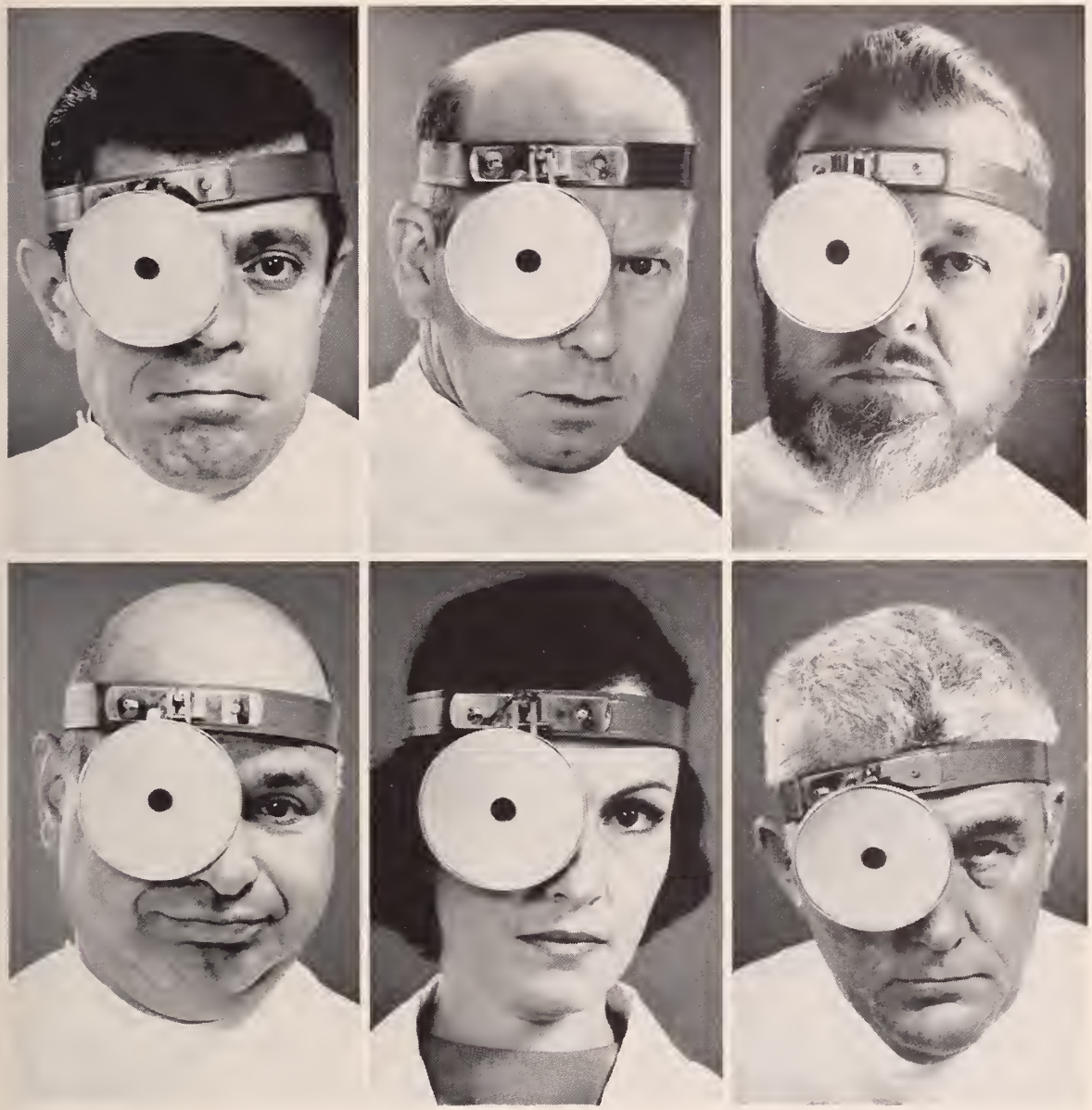
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(However, adverse reactions may occur. For a complete listing, please refer to the full prescribing information which is summarized below.)

when your patient wants an easy-to-remember and reasonably priced regimen. (One tablet a day usually costs about a dime.)

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue 1 week before electroshock therapy, and if depression or peptic ulcer occurs. **Use in pregnancy:** Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn. **Precautions:** Antihypertensive therapy with Regroton should always be initiated cautiously in post-sympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. **For details, see complete Prescribing Information.** (B)46-600-B

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Regroton® **Geigy**

Sustained circulatory, respiratory and cerebral stimulation for the

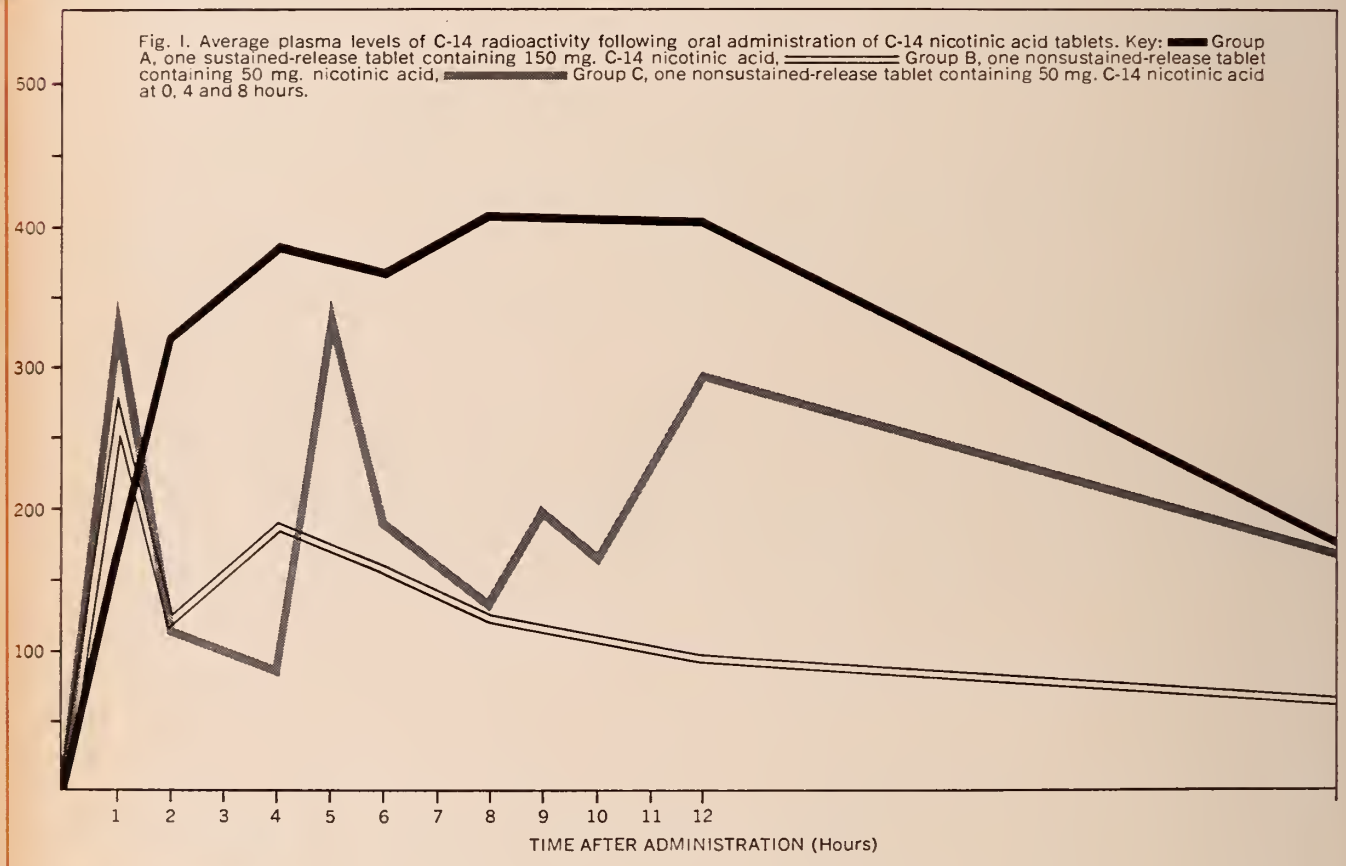


Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.



(fewer absent doses by absent-minded patients)

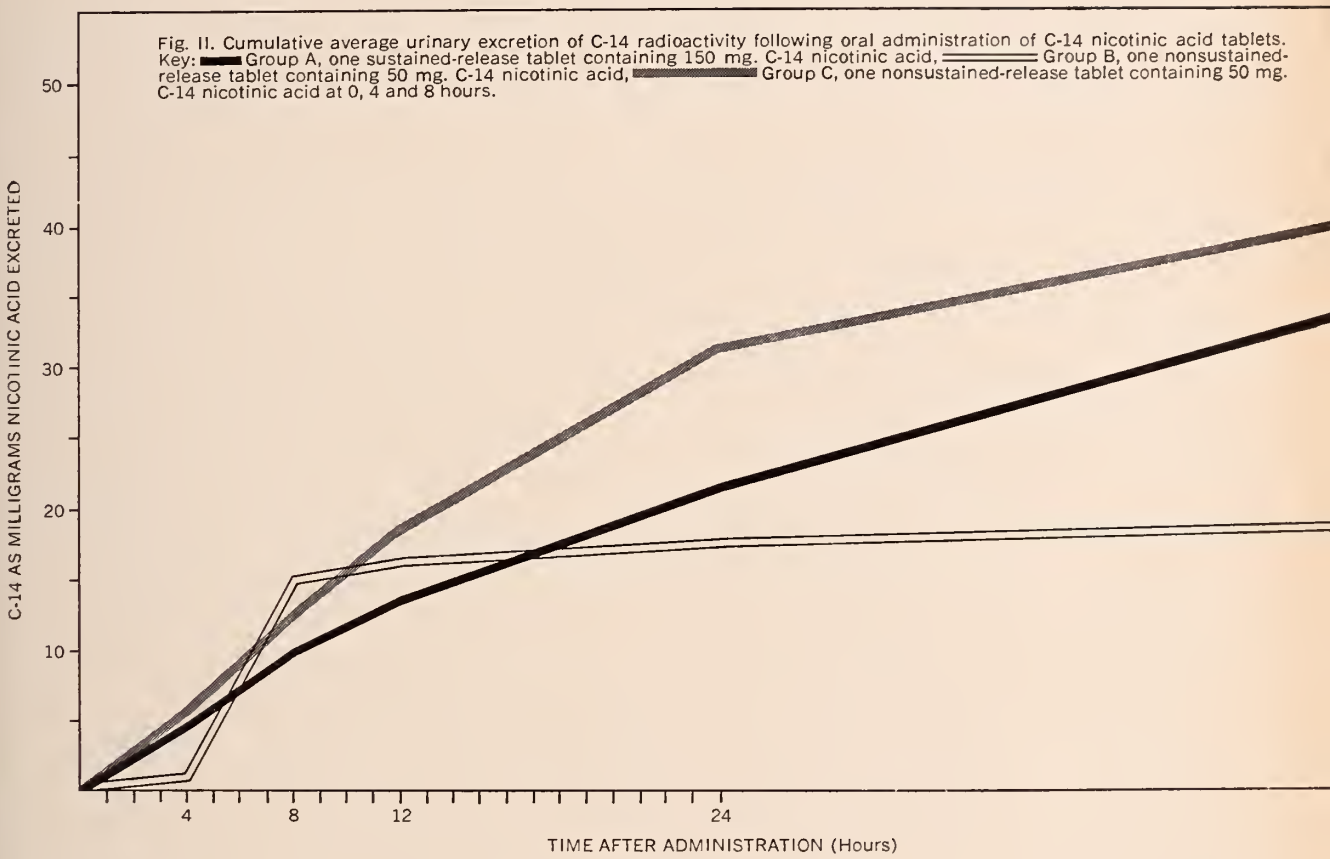
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

aged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol® TT
nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet





Tissue's healing nicely. Yet anxiety slows his steps toward recovery.

By helping overcome anxiety and tension which can thwart the convalescent's progress, Equanil® often may play an important role in medical and surgical aftercare.

ndications: For use in management of anxiety and tension occurring one or as accompanying symptom complex to medical and surgical sorders and procedures. Though not a hypnotic, fosters normal ep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported.

One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REOIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Wyeth® SERVICE TO MEDICINE

Equanil®

(meprobamate)

Wyeth

Professionally posed.

"Prescribe With Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

Barefoot Freedom

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR FOR MEN - WOMEN - CHILDREN
OUTFLAIR SHOES FOR CLUB FEET

69 WESTWOOD AVENUE
WESTWOOD, N. J.

350 MAIN STREET
HACKENSACK, N. J.

Dennis Brown Splints — In all sizes — Carried in stock
CUSTOM SHOE SHOP ON PREMISES

in the treatment of
IMPOTENCE



Android®
(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY
ANDROID — GOOD TO EXCELLENT 75%
PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

Android-E* *also available with ESTROGEN*

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg.
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen; only steroid effect remains. Geriatrics, post operative and debilitating disease, osteoporosis. DOSE: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. SIDE EFFECTS: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. CONTRAINDICATIONS: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 *strengths*

Android
Each yellow tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily
Available:
Bottles of 100, 500, 1000

Android-HP
HIGH POTENCY
Each red tablet contains

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY
Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:
BROWN **THE BROWN PHARMACEUTICAL CO.**
2500 W. 6th St., Los Angeles, Calif. 90057

Cash Lacks Interest,
. . . here it earns it.

4½% on Regular or 5%
on Investment Bonus
Savings Accounts

Call or visit us for details

Orange Savings Bank

MAIN OFFICE – Main and Day St. ESSEX DRIVE-IN OFFICE – So. Essex Ave. at Henry St.
Member F.D.I.C.

IDEAL DAIRY FARMS
UNION, N. J.

Country-Produced Milk

RETAIL WHOLESALE

2331 Morris Ave. Union, N. J.

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CAPTAIN STARN'S
SEAFOOD
RESTAURANT & YACHT BAR
Steaks and Chops
All Kinds of Yachting
Featuring Seafood From
Our Own Boats
Inlet — Atlantic City, N. J.
Phone 344-3905 Ample Parking



Blessed event?

Not entirely, when nausea and vomiting occur in early pregnancy. Emetrol offers prompt and safe relief. Local rather than systemic action provides emesis control on contact with the hyperactive G.I. tract.* In a study of 123 pregnant women, the drug produced measurable improvement in 79% of patients in controlling vomiting.[1]

*As shown by *in vitro* studies.
1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. *65*:311 (Feb.) 1953.



Emetrol®
phosphorated carbohydrate solution
emesis control

ROBERER
WILLIAM H. RORER, INC.
Fort Washington, Pa.



What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects intestinal mucosa.

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent)..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified).... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls three times daily.

RORER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

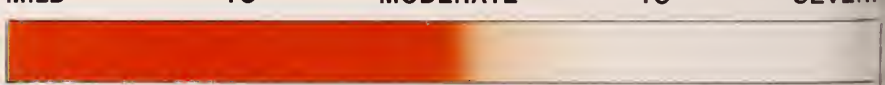
Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERI



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

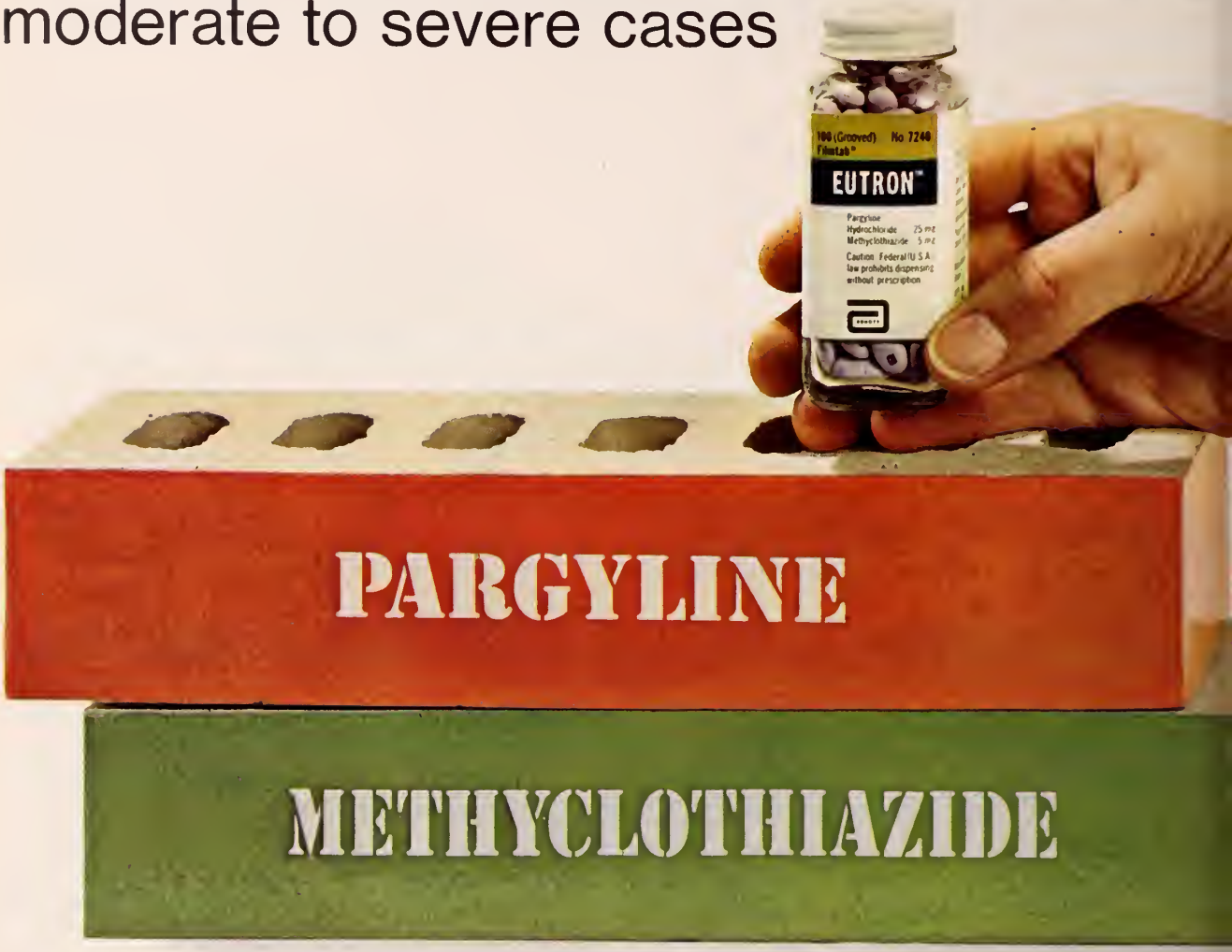
MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

ABBOTT

TM-TRADEMARK

1968 Annual Meeting

SPEAKERS

Saturday through Wednesday
May 18 to 22, 1968

Chalfonte-Haddon Hall
Atlantic City

Ackerman, Milton, Atlantic City
Aitken, Gerard J., Jr., New Brunswick
Ayres, Stephen M., New York

Barnshaw, Harold D., Camden
Boone, Reverend William J., Montclair
Breen, James L., Newark
Brennan, James E., Camden
Bromley, John W., Paterson
Brunt, Harry H., Jr., Hammonton
Butler, James B., Trenton

Cavanagh, Denis, St. Louis
Cohen, Philip, Paterson
Corral, Hector, Red Bank
Cosgriff, Stuart W., New York

Davidson, Henry A., Cedar Grove
Demos, Nicholas J., Jersey City
Detrano, Salvatore J., Union City
Dibadj, Ahmad, Atlantic City
Drossner, Jacob L., Pennsauken

Fielding, J. William, New York
Finnesey, Robert V., South Orange
Fisher, Alexander A., Woodside
Freiberger, Robert, New York

Galen, Noel C., Englewood
Gambino, S. Raymond, Englewood
Gelb, Jerome, Irvington
Germain, Mrs. Carol P., Metuchen
Goldberg, Theodore H., Westwood
Goldfischer, Jerome D., Fort Lee
Griswold, Merton L., Jr., Plainfield
Gurney, Clifford W., Highland Park

Hallett, E. Bruce, Morristown
Hanfling, Seymour L., East Orange
Hansen, Harold T., South Orange
Harbert, Frederick, Philadelphia
Hare, George T., Camden
Hildick-Smith, Gavin Y., New Brunswick
Hunt, Congressman John E., Pitman

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Kimball, John T., Jr., New York
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Koven, Bernard J., Englewood
Krosnich, Arthur, Trenton
Kupperman, Herbert S., New York

Lasker, Norman, Jersey City
Leadbetter, Guy W., Jr., Burlington, Vermont
Lehmann, Otto, Long Branch
Levine, Rabbi Reuben R., Springfield
Lewin, Michael, Paterson
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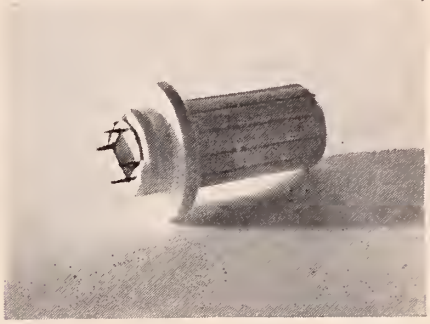
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1968 Annual Meeting

RÉSUMÉ OF EVENTS

Saturday through Wednesday
May 18 to 22, 1968

Chalfonte-Haddon Hall
Atlantic City

Registration

Saturday, May 18 from 10:00 a.m. to 4:30 p.m. Sunday, Monday and Tuesday, May 19, 20, and 21, from 9:00 a.m. to 4:30 p.m. Wednesday, May 22, from 9:00 a.m. to 12:00 noon.

Golden Merit Award

Saturday, May 18 at 1:00 p.m. Honored will be those members of MSNJ who have held the degree of Doctor of Medicine for fifty years. Reception following ceremony.

House of Delegates

First session—Saturday, May 18 at 3:00 p.m.
Second session—Sunday, May 19 at 3:15 p.m. - (Election)
Third session—Tuesday, May 21 at 9:30 a.m.

Medical-Surgical Plan

Saturday, May 18—At the close of the first session of the House of Delegates there will be an open discussion on the Medical-Surgical Plan.

Reference Committees

Sunday, May 19 at 10:45 a.m.

Scientific Program

Special Scientific Sessions (Co-sponsored)
Sunday, May 19 from 9:30 to 11:30 a.m. and from 1:00 to 3:00 p.m.

Scientific Section Sessions

Monday, May 20 from 9:00 to 11:30 a.m. and from 2:00 to 4:30 p.m.
Tuesday, May 21 from 2:00 to 4:30 p.m.

Clinical Pathologic Conference

Wednesday, May 22 from 10:30 a.m. to 12:00 noon

Motion Picture Theatre

Sunday, May 19, starting at 2:00 p.m. Monday and Tuesday, May 20 and 21, starting at 10:00 a.m., and again at 2:00 p.m. Wednesday, May 22, starting at 10:00 a.m.

Exhibits

Informational—Sunday, May 19, from 12:00 noon. Monday and Tuesday, May 20 and 21, from 9:00 a.m. Wednesday, May 22 from 9:00 a.m. until 12:00 noon.

Scientific—Sunday, May 19, from 12:00 noon. Monday and Tuesday, May 20 and 21, from 9:00 a.m. Wednesday, May 22 from 9:00 a.m. until 12:00 noon.

Technical—Sunday, May 19, from 12:00 noon. Monday and Tuesday, May 20 and 21, from 9:00 a.m. Wednesday, May 22 from 9:00 a.m. until 12:00 noon.

General Session

Sunday, May 19, at 4:00 p.m. Address of Incoming President, Dr. John F. Kustrup. Presentation by President-Elect of the American Medical Association, Dr. Dwight L. Wilbur.

Reception for President-Elect

Sunday, May 19 at 6:00 p.m. Members, guests, wives of members and guests, and Auxiliary members are invited to attend a reception honoring the President-Elect, Dr. John F. Kustrup. (Admission by badge)

Dinner-Dance

Monday, May 20 at 7:00 p.m. Members, guests, wives of members and guests, and Auxiliary Members are invited to attend a dinner-dance in honor of President and Mrs. Louis K. Collins. (Tickets at the Registration Desk—$11 per person)

Exhibitors Reception-Buffet

Tuesday, May 21 at 7:00 p.m. Reception and buffet honoring annual meeting exhibitors (By invitation only)

Miscellaneous

Saturday, May 18 at 5:30 p.m.—Reception—Essex County Medical Society (By invitation only)

Saturday, May 18 at 7:00 p.m.—Officers' Dinner (By invitation only)

Monday, May 20 at 7:30 a.m.—Breakfast—JEMPAC. Reservations: Marshall Driggs, M.D., 245 Engle Street, Englewood.

Monday, May 20 at 12:15 p.m.—Luncheon—New Jersey Orthopaedic Society. Reservations: William U. Cavallaro, M.D., 382 Springfield Avenue, Summit.

Tuesday, May 21 at 5:30 p.m.—Open House—Jefferson Medical College Alumni.

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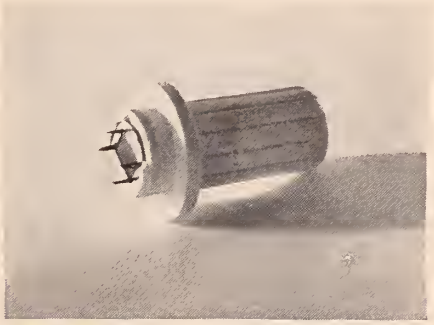
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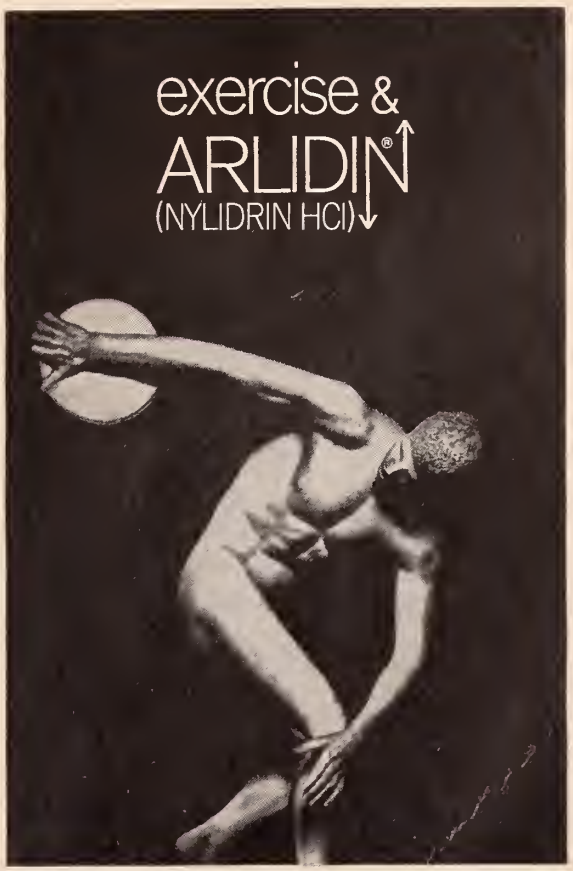
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MAY 1968
VOL. 65, No. 5

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THE JOURNAL is published monthly (since 1904) by The Medical Society of New Jersey — under the direction of the Publication Committee — 315 West State Street, Trenton, New Jersey. Phone: 394-3154 (Area Code 609); Printed and Published at Periodical Press, 3rd and Hunting Park Avenues, Philadelphia, Pennsylvania.

SUBSCRIPTION RATES — Price per year in advance, including postage: United States, $5. Foreign, $5, plus postage.

SINGLE COPIES—50 cents each. If more than two years old, $1 each.

Second-class postage paid at Philadelphia. Address all communications for publication to P. O. Box 904, Trenton, New Jersey 08605.

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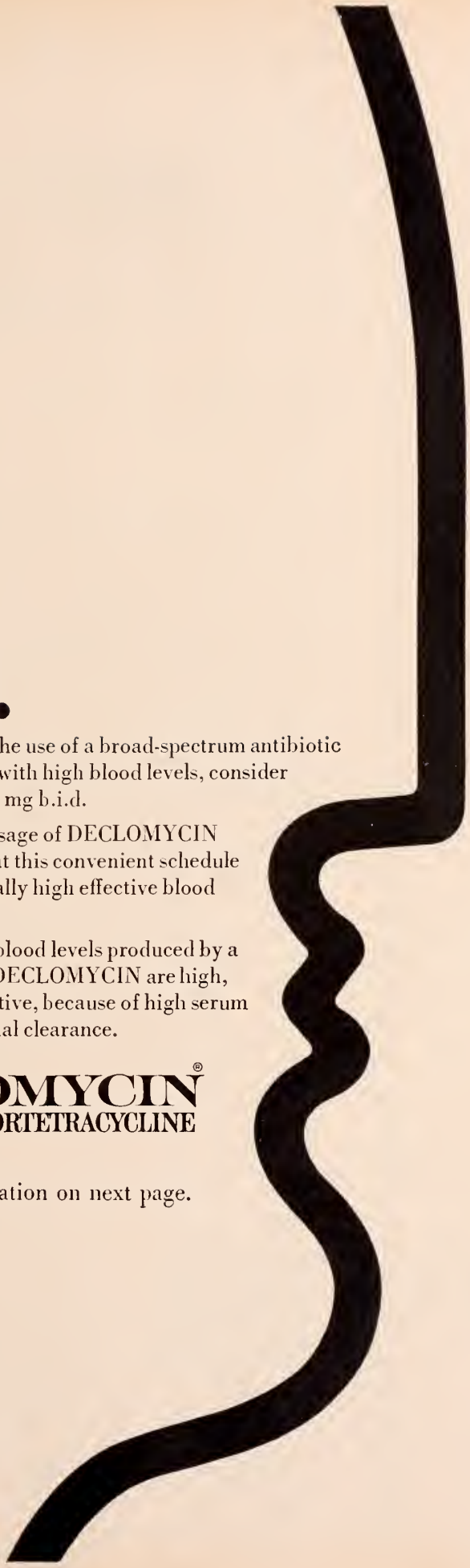
The maintenance dosage of DECLOMYCIN 300 mg can be kept at this convenient schedule because of its unusually high effective blood and tissue levels.

In clinical practice, blood levels produced by a therapeutic dose of DECLOMYCIN are high, prolonged, and effective, because of high serum binding and slow renal clearance.

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Prescribing information on next page.



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DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg every 6 hours for a minimum of 4 doses or 300 mg every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg every 6 hours or 300 mg every 12 hours until a cure is effected.

Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg in 3 divided doses for six days.

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379-8

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Before prescribing, see complete information, including adverse effects reported with phenothiazines and symptoms and treatment of overdosage, in SK&F literature or *PDR*. The following is a brief precautionary statement.

Contraindications: Comatose states or the presence of large amounts of C.N.S. depressants.

Precautions: Potentiation of C.N.S. depressants may occur (reduce dosage of such agents when used concomitantly). Use with caution in patients with chronic respiratory disorders. Antiemetic effect may mask overdosage of toxic drugs or obscure other conditions. Administer in pregnancy only when necessary. Because of possible drowsiness use cautiously and warn patients who operate vehicles or machinery.

Adverse Reactions: Drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; miosis; mild fever; weight gain; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosages (in rare instances, may persist); lactation and moderate breast engorgement (in females on high dosages); and less frequently, cholestatic jaundice (use cautiously in patients with liver disease). Adverse reactions occurring rarely, include: mydriasis; agranulocytosis; skin pigmentation; epithelial keratopathy; lenticular and corneal deposits (after prolonged substantial doses).

Available: Tablets, 10 mg., 25 mg., 50 mg., 100 mg. and 200 mg.; Spansule® capsules, 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg.; Injection, 25 mg./cc.; Syrup, 10 mg./5 cc.; Suppositories, 25 mg. and 100 mg.

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Some U.R.I. patients are more miserable than others.

That's why we make Novahistine® tablets in two different formulations.

And let you control the dosage.



Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg.; and chlorpheniramine maleate, 4 mg.
Each Novahistine Singlet tablet contains phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; and acetaminophen, 500 mg.

With Novahistine LP tablets and Novahistine Singlet™ tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever. Novahistine Singlet tablets, which provide analgesic-antipyretic effect, as well as decongestant action, are indicated for upper respiratory infections accompanied by pain, aches and fever.

Whether you prescribe Novahistine LP or Novahistine Singlet, a total daily dose of 3 or 4 tablets will usually provide effective, continuous relief.

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For quick, complete information, please refer to P.D.R. 1968, page 697. Literature and samples available upon written request.

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Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

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The therapeutic action is smooth, and persists for a full 24 hour With Enduron you can prescribe convenient once-a-day dosag without skimping your patients on day-long thiazide effectivenes

Of course, as with all thiazides, supplemental dietary potassiu should also be considered.

Use Enduron as a basic therapy in patients with mild to mo erate hypertension. A single 5-mg. tablet each day is ample i most cases.

Once a day, every day

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METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVE



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Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

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Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

MILD TO MODERATE TO SEVERE



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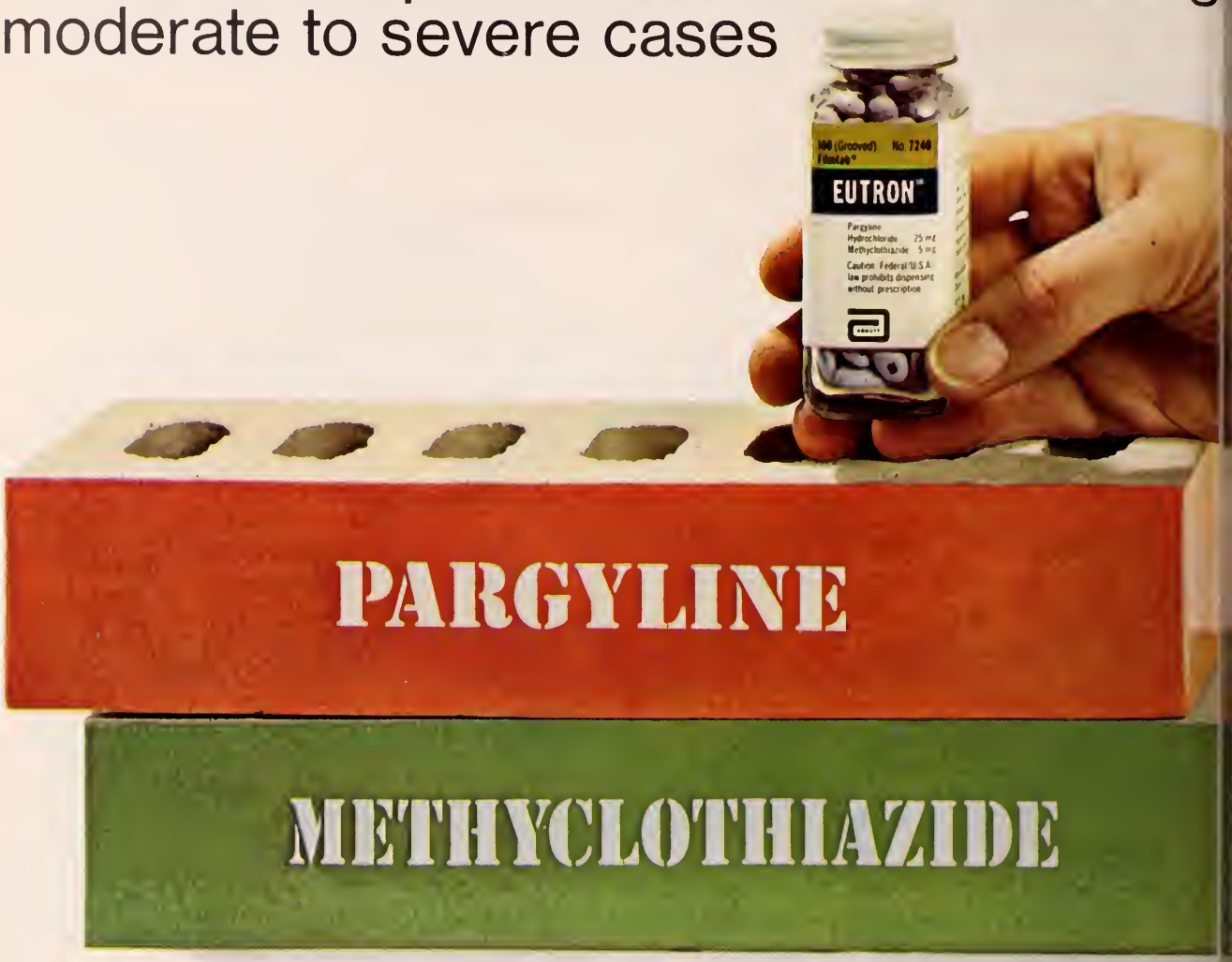
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METHYCLOTHIAZIDE 5 mg. with DESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

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Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether you patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

Use Eutron for managing your moderate to severe cases. It building blocks enhance each other; hence lesser doses often suffice

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PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

8010

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage: caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions — Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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anorectic action with fewer unwanted side effects



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(levamfetamine succinate TUTAG)



Cydril at 2 p.m.
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Action and Uses: Cydril (levamfetamine succinate) is a chemopharmaceutical approach to aid the obstinately obese. Cydril (levamfetamine succinate) provides the appetite depressant action of amphetamines but exhibits fewer unwanted side reactions.

Dosage: Adults and 'teenagers', one (1) Cydril (levamfetamine succinate) Granucap* daily.

Side Effects: Occasionally cardiovascular and gastrointestinal reactions may produce dry mouth, metallic taste, anorexia, nausea, diarrhea, headache, chilliness, pallor or flushing, sweating, diuresis, and arrhythmias.

Contraindications: Cydril (levamfetamine succinate) should not be used in the presence of severe hypertension, angina pectoris, hyperthyroidism, and Raynaud's disease.

*Granucap is the Tutag brand of sustained release capsule manufactured to release the contents over a period of approximately 6 to 10 hours.

Caution: Federal law prohibits dispensing without prescription.

Full product information available on request or see page 1122 in your 1967 PDR.

For more about CYDRIL and the Cydril Family of Products ask the Man from Tutag (or your colleagues)

S. J. TUTAG & CO. ETHICAL PHARMACEUTICALS
DETROIT, MICHIGAN 48234



When eating fads of teens or tots Lead to a sudden case of "trots"

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric*
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin,
and protects intestinal mucosa

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

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Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) . . . . . (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin . . . . . (2½ grains) 162 mg.
Kaolin (specially purified) . . . . (85 grains) 5.5 Gm.
(alcohol 0.69%)

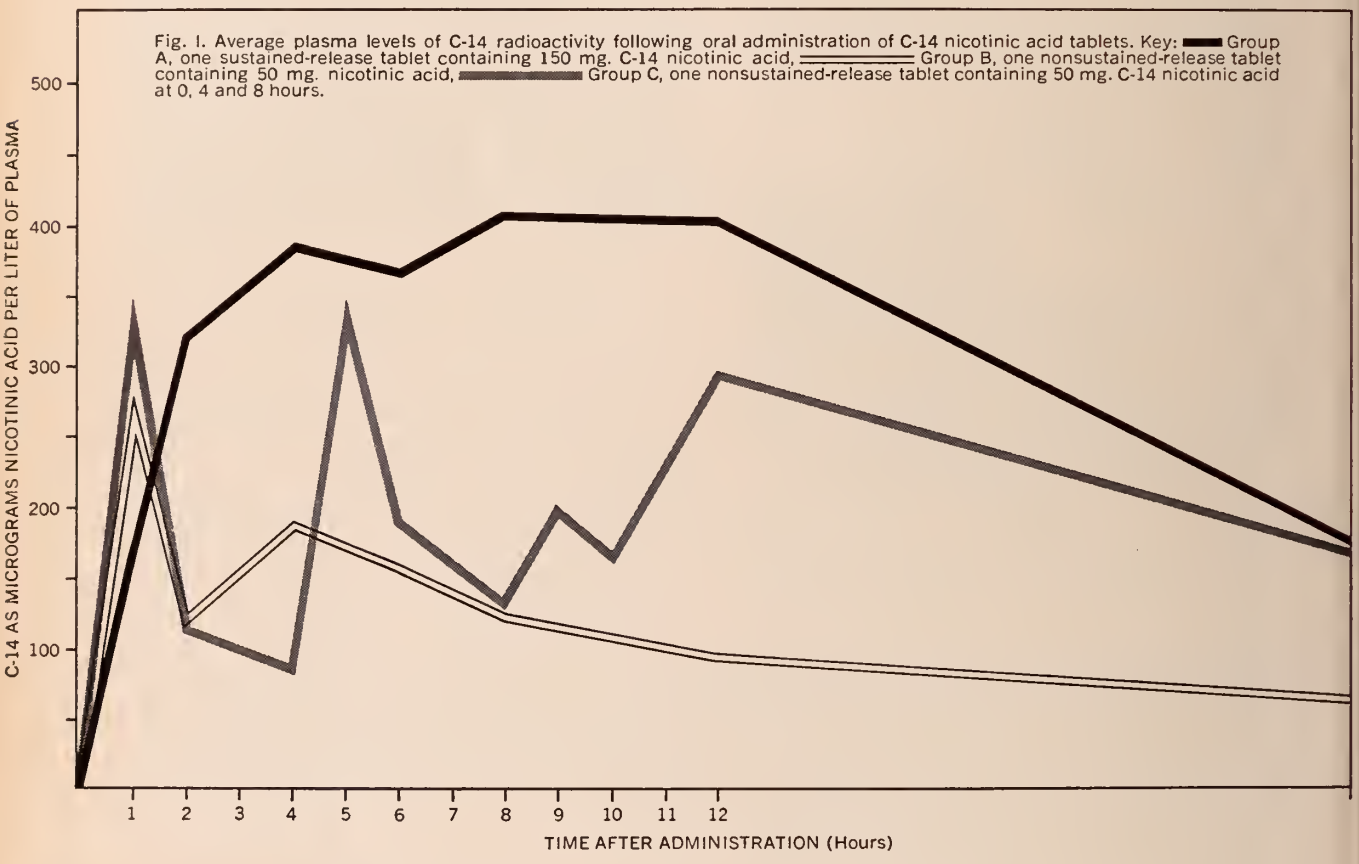
Usual Children's Dose: One or two teaspoonfuls three times daily.

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

Sustained circulatory, respirator
and cerebral stimulation for th

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

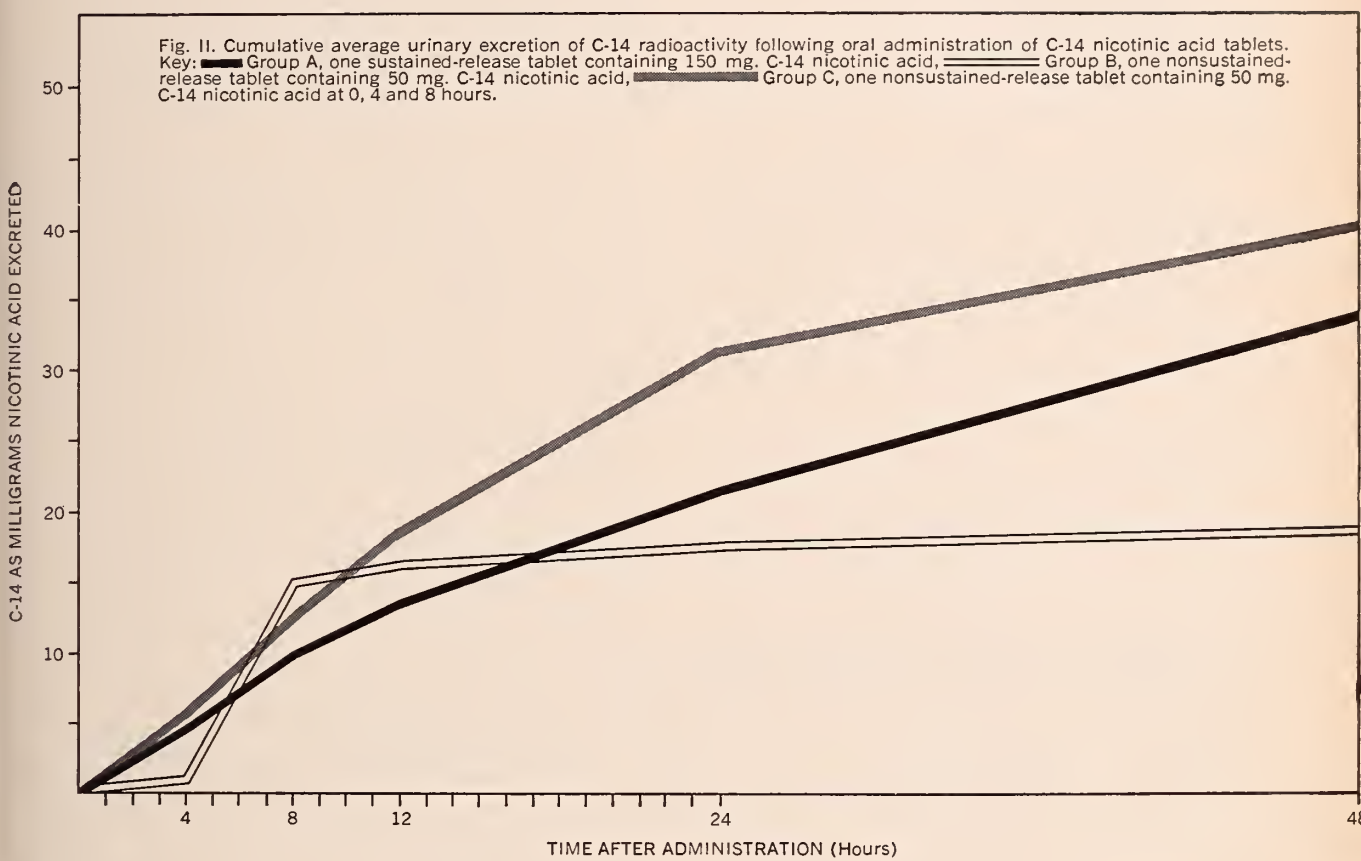
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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nicotinic acid 150 mg., pentylenetetrazol 300 mg.
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Motion sickness?



This time it'll be different. Emetrol taken before the trip begins will usually prevent nausea and vomiting. Emetrol is effective and safe...most helpful where safety is most important. It acts locally—not systemically.

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Emetrol®
phosphorated carbohydrate solution
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IMPOTENCE



Android®

(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impatence treatment with methyl testasterane - thyraid (ANDROID) a double blind study" - Mantesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android

Each yellow tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . 10 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (¼ gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
Glutamic Acid . . . . . 100 mg.
Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 . . . . . 2.5 mcg.
Riboflavin . . . . . 5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

also available with ESTROGEN

Android-E

Each Tablet Contains:
Methyl Testosterone . . . . . 2.5 mg.
Ethinyl Estradiol . . . . . 0.02 mg.
Thyroid Ext. (1/6 gr.) . . . . . 10 mg.
Thiamine Hydrochloride . . . . 10 mg.
Glutamic Acid . . . . . 50 mg

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen – only steroid effect remains. Geriatrics, post operative and debilitating disease, osteoporosis **DOSE:** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens hoarseness, hirsutism, enlarged clitoris Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month **CONTRA-INDICATIONS.** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Is it depression?

She says "I can't sleep..."



...but her other symptoms:

anxiety, loss of interest, anorexia, psychomotor retardation

strongly suggest an underlying depression.

---

when the diagnosis is depression

ELAVIL® HCl

AMITRIPTYLINE HCl

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

Before prescribing or administering, read product circular with package or available on request.

MERCK SHARP & DOHME Division of Merck & Co. Inc. West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

IMPORTANT FACTS

about

Professional Liability Coverage

Insurance that only covers claims based on the rendering of, or failure to render, professional services, or arising out of malpractice error or mistake in rendering professional services, is no longer adequate.

Our policy, approved and recommended by The Medical Society of New Jersey is broad enough to cover:

(1) the non-negligent as well as the negligent claim, such as arising out of duties as committee member in your society or hospital.

(2) The financial loss to a physician in attending trial as a defendant in protracted litigation.

(3) punitive damages for libel or slander.

This program, which was designed with The Medical Society of New Jersey and its legal counsel, and operated by a cooperative Loss Control Program, offers this broad protection, security and continuity of coverage.

Complete protection should not
be controlled by price.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

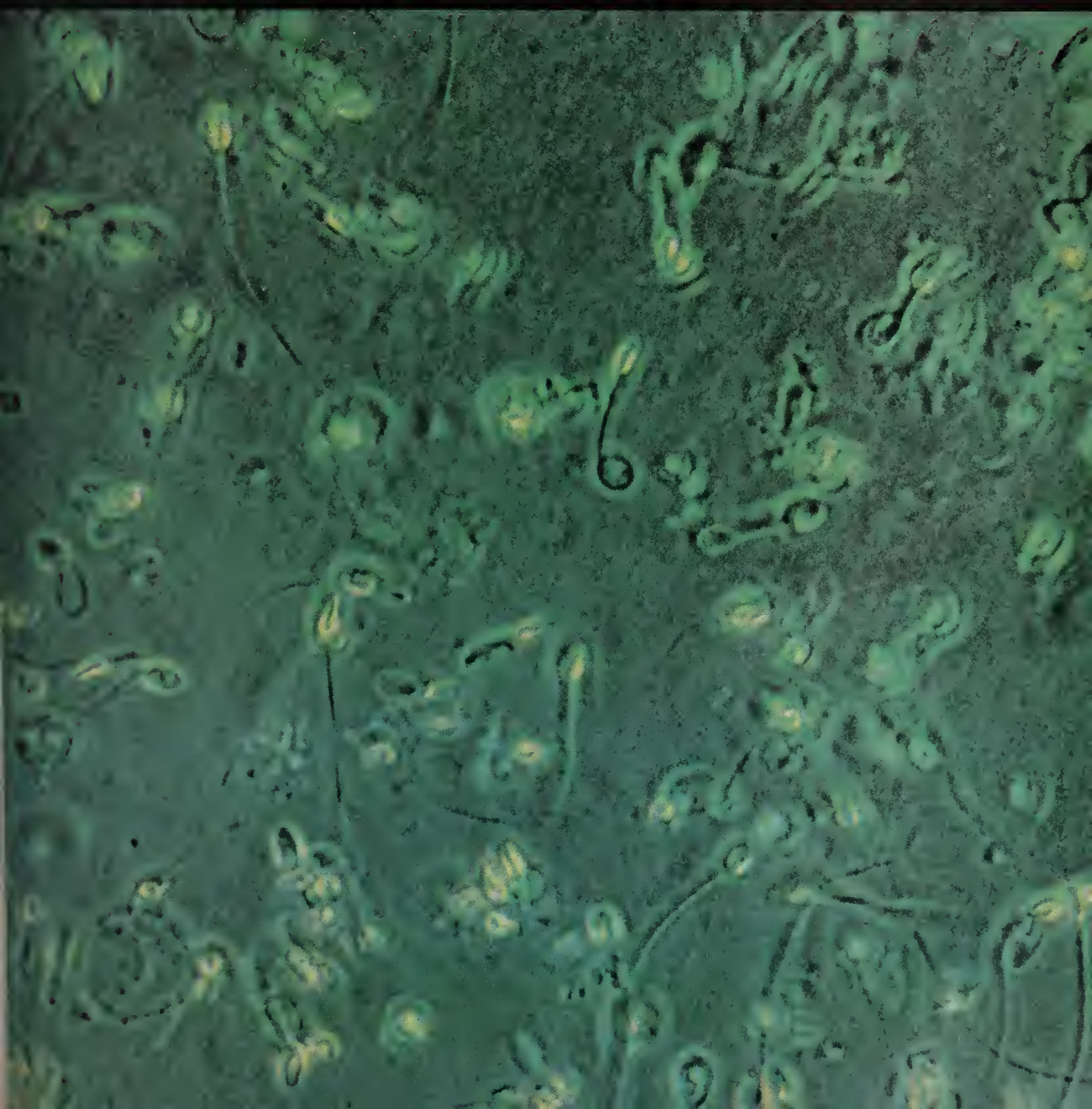
Professional Liability Department

725 PARK AVENUE EAST ORANGE, NEW JERSEY 07017
William K. Richardson, Acting Manager ORange 3-2575
Home Office: Wakefield, Mass.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg + mestranol 0.05mg)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of NORINYL-1 (norethindrone 1 mg. with mestranol 0.05 mg.) in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with NORINYL-1. Therefore, if such tests are abnormal in a patient taking NORINYL-1 it is recommended that they be repeated after the drug has been withdrawn for two months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. 5. NORINYL-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, and as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged NORINYL-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving NORINYL-1 therapy. 10. Because of the occasional occ rence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the dis ease. 11. Because of the effects o estrogens on epiphyseal closure, NORINYL-1 should be used jud ciously in young patients in whc bone growth is not complete. 12. age of the patient constitutes no absolute limiting factor, althoug treatment with NORINYL-1 ma mask the onset of the climacteri 13. The pathologist should be ac vised of NORINYL-1 therapy w relevant specimens are submitte

Side effects observed in patients receiving oral contraceptives: T following adverse reactions hav been observed in patients receiv oral contraceptives: nausea, vor ing, gastrointestinal symptoms as abdominal cramps and bloati breakthrough bleeding, spottin change in menstrual flow, amen rhea, edema, chloasma or melas breast changes (tenderness, enl ment and secretion), change in (increase or decrease), changes cervical erosion and cervical sec suppression of lactation when immediately postpartum, chole jaundice, migraine, rash (allerg rise in blood pressure in suscep individuals, mental depression.

Although the following side eff have been reported in users of c contraceptives, no cause and ef relationship has been establish anovulation post-treatment, premenstrual-like syndrome, cl in libido, changes in appetite, c like syndrome, headache, nerv dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema sum, hemorrhagic eruption, it

The following occurrences hav observed in users of oral contra tives (a cause and effect relatio has been neither established n proved): thrombophlebitis, pul embolism, neuro-ocular lesion

The following laboratory resul may be altered by the use of or contraceptives: increased sulfo bromophthalein and other hep function tests, coagulation test (increase in prothrombin, Fact VII, VIII, IX and X), thyroid fu tion (increase in PBI and butan extractable protein-bound iodi decrease in T^3 values), metyra test, pregnanediol determinati

norethindrone — an original steroid f
SYNTEX
LABORATORIES INC., PALO ALTO, CAL

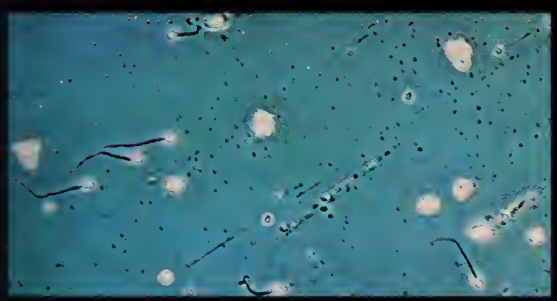
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

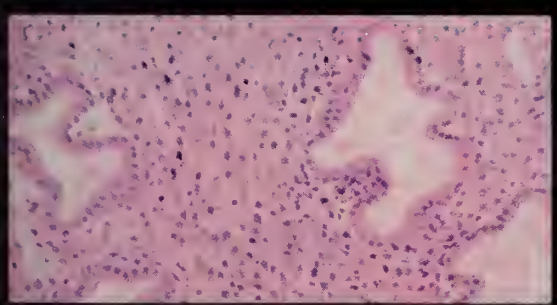
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

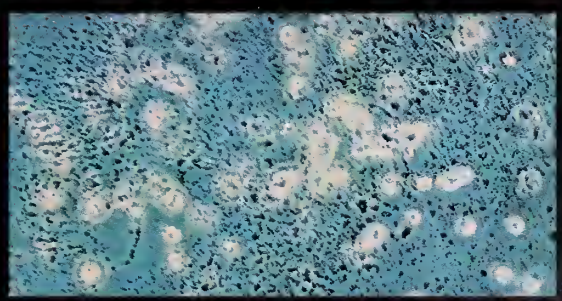


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

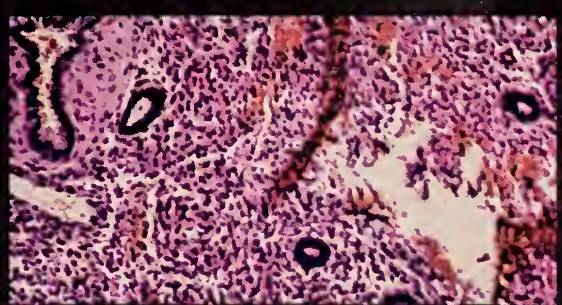
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



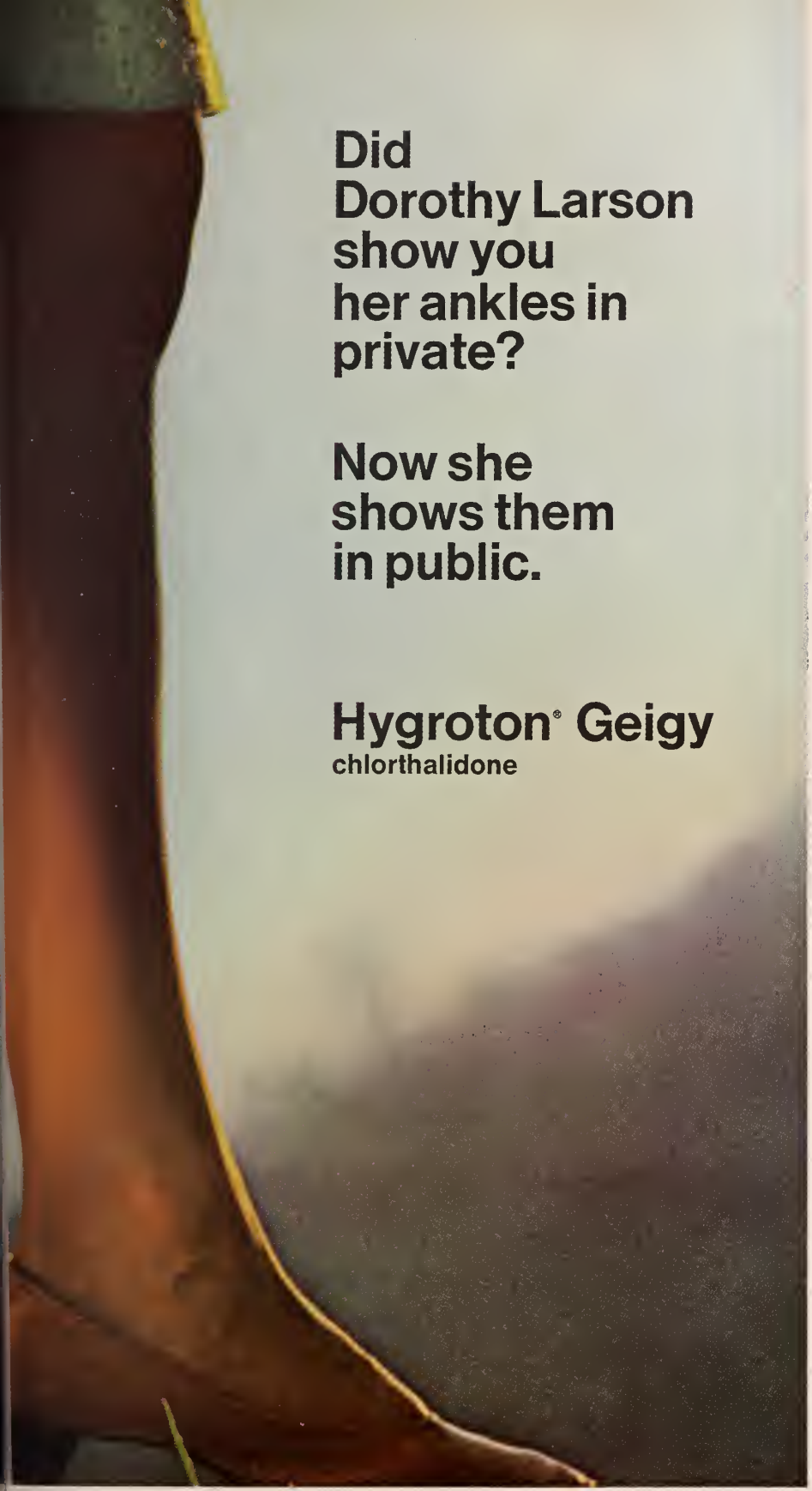
Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1
(norethindrone 1mg & mestranol 0.05mg) tablets

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost



Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension b cause of the possibility of p sion of renal damage, perio determination of the BUN is cated. Discontinue if the BU or liver dysfunction is aggra Hepatic coma may be preci Electrolyte imbalance, sodi or potassium depletion may If potassium depletion shou cur during therapy, Hygrotc be discontinued and potass supplements given, provide



Did Dorothy Larson show you her ankles in private?

Now she shows them in public.

Hygroton® Geigy
chlorthalidone

Your office examination confirmed Mrs. Larson's ankle edema.

You prescribed Hygroton to get rid of the edema.

And you found that Hygroton is not only usually effective; it frequently costs less than other equivalent therapy.

A nice way to treat the Mrs. Larsons in your practice.

Hygroton therapy may mean troublesome side effects for some patients. And you can't prescribe it for patients with hypersensitivity to the drug or severe renal or hepatic diseases. Before writing it for your patients, please check the prescribing information. It's summarized below.

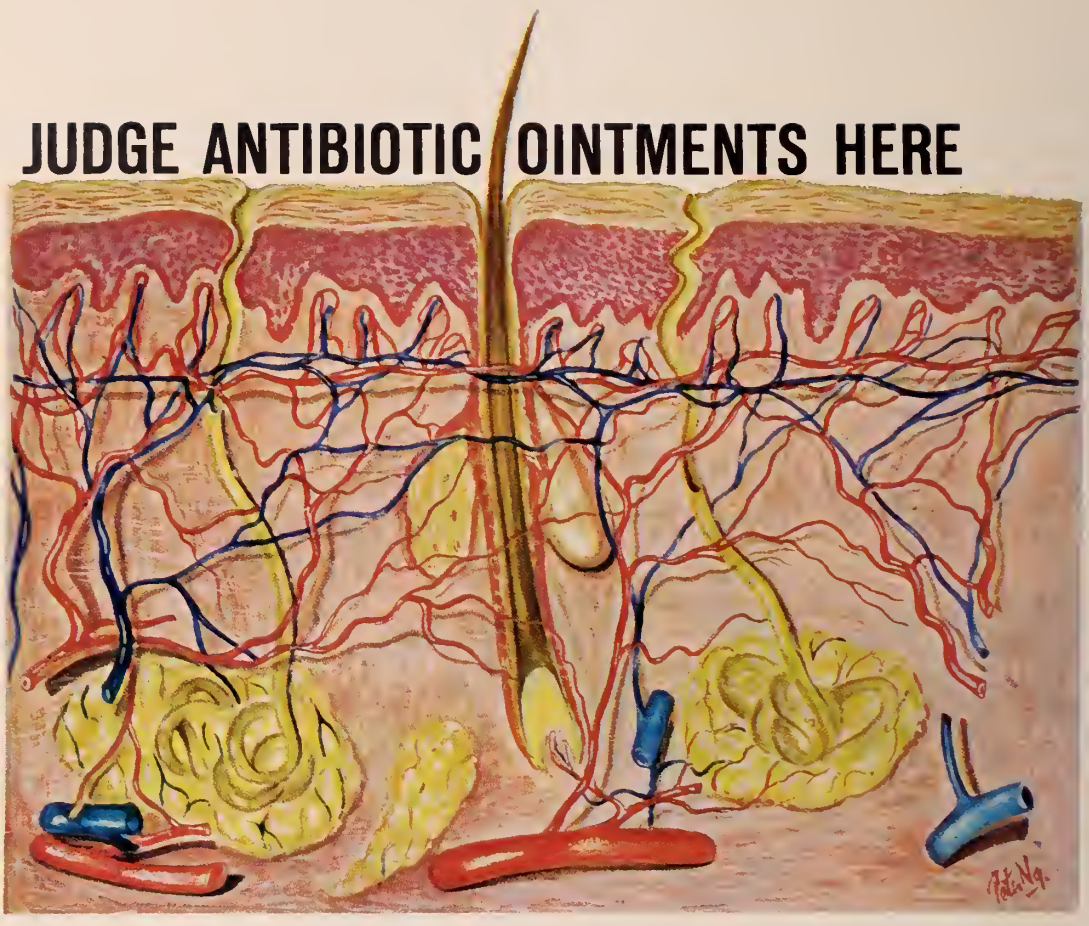
t does not have marked oli-

pecial care in cirrhosis or
ischemic heart disease and
ents receiving corticoste-
ACTH, or digitalis. Salt re-
on is not recommended.
se Reactions: Nausea, gastric
on, vomiting, anorexia, con-
on and cramping, dizziness,
ess, restlessness, hyperglyc-
, hyperuricemia, headache,
e cramps, orthostatic hypo-
tension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.
Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.
Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.
(B)R46-230-D
For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY-5908

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Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Weariness without cause"



Psychic tension with depressive symptomatology?

"For weeks I've done practically nothing and I'm always tired. I wake up tired and I go to bed tired. It's really absurd."

When the patient complains of fatigue, and you can find no organic cause, you recognize that it may serve her as a means of avoiding responsibilities or facing an emotional problem. It is, in effect, a psychological retreat behind a somatic cover of continuous fatigue —one of the many depressive symptoms often associated with psychic tension.

She needs counsel and reassurance, and perhaps a tranquilizer to attenuate excessive tension and help restore the capacity to cope. As an aid to successful management, consider the value of Valium® (diazepam). As psychic tension is eased by Valium therapy, secondary depressive symptoms too may subside. The patient feels more capable, therefore more hopeful; better able to handle situations of intense stress.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects —particularly with known compounds which may potentiate action of Valium, such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly reported: drowsiness, fatigue and ataxia. Infrequently encountered: confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo and blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, use of the drug should be discontinued. Because of isolated reports of neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See **Precautions**.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg, and 10 mg; bottles of 50, 100 and 500.

ROCHE

Roche LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Valium® (diazepam)

helps relieve psychic tension with associated depressive symptoms



"When you're finished with baby,
maybe you can tell me what I can do about my extra pounds."

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain.* When a new dietary pattern must be established, consider the adjunctive use of BAMADEX SEQUELS. Combining the proven *anorexigenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, BAMADEX SEQUELS controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex® Sequels®

Dextro-Amphetamine Sulfate (15 mg.) with Meprobamate (300 mg.) Sustained Release Capsules

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York

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Part of
the fine art
of medicine



DARVON®
COMPOUND-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Additional information available to physicians upon request.
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INDIANAPOLIS, INDIANA 46206

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EDITORIALS

Bon Voyage, Terrie

Her official name is Theresa E. Goeke, but to the Medical Society family she's always been Terrie. She's been with the Society for 17 years, and in that period she has become such a dependable and skillful worker that it is going to be hard to imagine the office without her. We stole her in the first place from the New Jersey Turnpike Authority. She came in as Edith Madden's secretary. Then our Executive Director transferred her to his office and she soon became a general administrative secretary. She did this all with her right hand but with her left hand, and with no visible evidence of strain, she also functioned for some years as Assistant Editor of this JOURNAL. In that capacity she was the liaison with the State Medical Journal Advertising Bureau and with our printer. She made up the advertising dummy, was my editorial secretary, secretary to the Publication Committee, processed manuscripts, proofread, handled much of the editors correspondence, and — why go on. (You must wonder what *I* did!)

But while Terrie did all that, she also was the Executive Assistant to the Executive Director of the Society, and in that capacity she worked at one time or another on the business of every committee and council of our Society — public relations, legislation, processing of grievances, and the myriad of other administrative and supervisory details that develop in any active office.

It sounds like quite a load: the JOURNAL and the service as Executive Assistant. But for Terrie it wasn't quite enough. *League Lights,* house organ of the Trenton Junior League, once featured Terrie in their "Spotlight" column, not only for her tremendous work for the League, but also for general community service: nurse's aide, hospital secretarial assistant (as a volunteer and in her so-called "spare time"), expert seamstress, skilled bridge player, and on and on.

Thus Terrie was an extraordinarily useful member of the Delaware Valley area. Incidentally, she was decorative there as well as useful. And she can even sing!

And now Terrie is going to realize in practice what a lot of us do in fantasy. She's going to do it, while most of us dream about it. She's taking a trip around the world! I saw her itinerary — Manila, Hong-Kong, Tokyo, Formosa, Bangkok, Singapore, Calcutta, Darjeeling, Katmandu, the Taj Mahal, and — but I'd better stop here before I start drooling. Anyway, you get the idea. Well, she expects to be home for Christmas, but won't be bound by any absolute promises.

Like all her friends, I am pleased that she is going to have this exciting and adventurous trip. But somehow, 315 West State Street won't be quite the same without Terrie. But she goes with the affection and best wishes of all of us. Henry A. Davidson, M.D.

Transplantation: Act Three

The "heart" of the matter: ah, that's the old one, isn't it? Heart transplants seem to be here, and brain transplants are waiting in the wings. Which raises the question — not "who are you?" but rather "what are you?" Replace your teeth with dentures and you are still you. Replace your hand with a prosthetic claw, and it's still the real you. But with a new heart and a new brain, are you still the old you or are you two other people? What new meaning will hence lurk beyond the admonition to "be yourself?" (Not, always good advice, by the way.) And with new transplants, the self-made man may become the surgeon-made man.

If organ transplants become as popular as appendectomies, the major problem is going to be a supply of donors. With paired organs like lungs or kidneys, the donor might sur-

vive after making his contribution. It reminds one of the old story of the chicken and pig seeing a sign: "Bacon and eggs." The chicken indicated pride in her contribution to this tasty breakfast. But the pig retorted: "For you, it's only a donation. But for me, it is total commitment." So it is with azygous organs like the heart, brain, and liver. How do we get donors to commit themselves totally to the contribution?

This produces two nightmares: the conventional one of the surgeon, poised over a dying person, waiting for the light to turn green so that he can pluck out the heart; and the less obvious thought that maybe we can breed a race of subhumans to provide healthy organs for unhealthy recipients. The first fear suggests a surgeon with itchy fingers waiting for the internist to say that while the heart is still beating the brain has stopped producing electroencephalographic tracings, therefore, the individual is "dead." Or the temptation offered by a respirator or dialyzing machine attached to a helpless and hopless body, where, by turning a switch or pulling an electric plug, the person "dies" (as he was doomed to die, anyway, it is comforting to know) and the organ becomes available.

At the time of their war against the intellect, the Nazis had suggested that the mentally retarded and deteriorated psychotic be considered less than human. So why not make available the healthy lungs, hearts, liver, and kidneys by declaring that all profoundly psychotic or retarded "people" be legally declared "non-persons?" Again, one can see the possibility of classifying as subhuman the members of the more helpless racial minorities. The Nazis considered gypsies, Jews, Slavs, and Negroes to be little less than human, so we have official precedent for this. Criminals and narcotic addicts could be added.

A man, faced with cerebral arteriosclerosis could buy a new brain with nice soft arteries. The transplantation of male genitalia or the hormones that work them opens up staggering possibilities. Come to think of it, a man could achieve immortality this way if only he has enough money to buy the appropriate organ replacements. Of course, this brings us back to the question of what is the real "you," if you had a total transplantation of brain, heart, lungs, and liver — plus a complete transfusion of blood.

Tomorrow, the hearse chaser may replace the ambulance chaser. Hearing that so and so is on the critical list, an organ broker may go to the next of kin and offer a substantial sum of money to turn the body over to the transplant surgeon when "the time comes," as it is delicately put. Maybe a new profession is being born: that of organ snatcher, or, perhaps, a Transplant Supply Merchant. If commissions are high, the TSMs might improve on *post-facto* hearse chasing by actually arranging accidents. American ingenuity is limitless.

Other possibilities suggest themselves. Right here in south Jersey (at Ancora) we have a suicide-prevention center. These are now opening up throughout the nation, and, indeed every new Community Mental Health Center is supposed to have suicide-prevention mechanisms. However, the need for organs leads to the possibility of developing suicide promotion facilities. And on the highways, near each of the traditional "dead-men's curves," we can have an organ transplant broker stationed to pick up the pieces.

A student, warming to this subject, might wonder about maintaining a supply, not only of donors, but also of good healthy organs. We could devise a new specialty (or is it an old one?) of keeping organs healthy. But to make sure that the donors wouldn't protest becoming warehouses of spare parts, maybe we'll have to develop a new kind of subhuman: one with healthy tissues but with no will to resist being destroyed in order to rejuvenate a less healthy, older, but richer client. And perhaps in our brave new world we can breed whole species — yea, whole "nations" or tribes of subhumans who will furnish organs for the aging but perpetually young among us.

Who says the old spirit of innovation and know-how is dead?

ORIGINAL ARTICLES

Title XIX is probably coming to our state. Here is a proposal for sound principles to cover its operation.

The Proposed Medicaid Program*

John F. Kustrup, M.D./Trenton

We wish, first of all, to express gratefulness and appreciation to both the Senate and Assembly Committees on Institutions and Welfare for the privilege of appearing today.

Because he must be in Chicago, it is impossible for the President of The Medical Society of New Jersey, Louis K. Collins, M.D., to appear before you. He has asked me to attend in his stead, together with Mr. Richard I. Nevin, Executive Director of the Society, and Mr. Vincent A. Maressa, Executive Assistant to Mr. Nevin. I am John F. Kustrup, M.D., President-Elect of The Medical Society of New Jersey. My practice is in Trenton, and I limit it exclusively to surgery.

The profession of medicine in the United States has historically and consistently been dedicated to the principle that no one should be denied necessary medical care because of inability to pay. Before the days of governmental underwriting of compensation for services rendered to the economically disadvantaged of our citizens, physicians and hospitals treated such patients without charge, in the spirit of charity.

When federal legislation was first considered to make government funds available to pay for health-care services, the medical profession, in conformity with its established principles, supported and approved the provision of public monies to pay for services rendered *to people unable to pay for themselves,* but opposed the use of such monies to pay for services rendered to people able to pay for themselves. Medicine therefore approved of the Kerr-Mills program to defray health care expenses for the over 65 indigent and medically indigent, but it opposed the Medicare program and its predecessors, which proposed subsidization of health care costs for citizens without regard to their financial capabilities.

It is an imposition to call upon taxpayers to provide funds to pay for services rendered to individuals able to pay for those services themselves, whether the beneficiaries are over 65 or not. Medicine's position in this regard was condemned as embodying an unacceptable and demeaning means test. Yet now, as we address ourselves to the implementation of Title XIX in New Jersey — the Medicaid program — one of the most important and controversial points to be dealt with is the determination of what means test shall be applied!

The Medical Society of New Jersey supports the purpose and intent of Title XIX to effect payment for health-care services rendered to the indigent and medically indigent of our State.

The evident thrust of Title XIX is to relieve people who are economically disadvantaged from the necessity of soliciting and accepting charity. Funds are to be made available, at federal and state levels, to defray the costs for health care services delivered to such people. The thought has been expressed that thus

* Dr. Kustrup, President-Elect of The Medical Society of New Jersey, made this statement on March 22, 1968, to a joint meeting of the New Jersey Senate and Assembly Committees on Institutions and Welfare.

they will no longer be "second class citizens" but, in consequence of the program, will be able to seek, receive, and indirectly pay for high quality health-care services of all kinds, on an equal basis with all other citizens.

The Medical Society of New Jersey, through its House of Delegates and its Board of Trustees, has adopted the following basic recommendations for inclusion in New Jersey's proposed Medicaid Program:

(1) The beneficiaries under the program should be assured free choice of physicians and hospitals. It should be noted that the Social Security Amendments of 1967 require that a state plan under Title XIX must provide that any eligible individual can obtain assistance from any institution, agency, community, pharmacy, or person qualified to perform services who undertakes to provide him with the service.

(2) Physicians should be free to administer treatment and prescribe medications in conformity with their best professional judgment and in conformity with their legal responsibility for the welfare of the patients under their care.

(3) Payment for physicians' professional services should be on the basis of their usual and customary charges. In this connection, we cite an HEW Bulletin — issued on August 9, 1965 to "State Agencies Administering Approved Public Assistance Plans" — which declared: "States must establish a realistic schedule of compensation for all services, preferably commensurate with 'reasonable cost' or 'reasonable charge,' and consistent with prevailing levels of payments within the communities concerned."

(4) The option should be available to physicians to bill directly to the patient or to the agency or insurance carrier. This would obviate the necessity of assignments, reduce paper work and delays, and provide a more economical method of administering the program.

(5) A qualified insurance carrier should be designated to process claims and payments for charges for medical services.

I should like to add a word about entitlement and coverage of the "medically indigent." It is our thinking that while determination of "indigency" may well be made by establishment of an income limit, "medical indigency" cannot equitably be so determined.

An indigent person, we accept, is one whose total income is inadequate to maintain him and/or his dependents at an adequate level of living. On the other hand, a medical indigent is a person whose resources are sufficient for the normal costs of his living, but prove inadequate to permit him to meet the added expenses of health care emergencies. A normally solvent person would thus become medically indigent when, under the impact of health-care expenses, his money and credit give out. As of such a time, when his resources are demonstrably exhausted, he should become eligible under the Medicaid program. To require him to fall into the income group of the indigent and to remain therein for a period of months is unrealistic and incompatible with the purpose of the program. One week of health-care charges for a really serious illness could easily reduce a normally self-supporting and self-sustaining person to medical indigency. Those charges should then be met for him to the extent to which he cannot meet them himself, and as soon as that status is reached. To leave him languishing in worry and debt would be contrary to the intent of the program and mentally and emotionally hazardous to his progress under treatment.

Again, Mr. Chairman, I thank you for the privilege of appearing here.

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The newer technology has made the implantable pacemaker a safe, reliable, effective, and acceptable device for heart block and other cardiac disorders.

Permanent Pacing Of The Heart

Attitudes and Methods

Victor Parsonnet, M.D., et al./Newark*

After more than seven years experience with implantation of permanent pacemakers, effective and safe operative methods have evolved. Although certain attitudes and methods are still changing, most of the principles of insertion of pacemakers have been fairly well established. This report describes present indications and technics for pacemaker insertion. We will, by analysis of our results, clarify those points that may appear controversial.

Method of Implantation

Essentially, there are three methods of implanting a pacemaker: transthoracic, subdiaphragmatic, and transvenous.[1] (Table I) We now use the transvenous method on all patients, because it can be done under local anesthesia in bad risk and aged patients with almost no mortality and little morbidity. Although at first there were many complications as methods were being worked out, these are now relatively infrequent and usually minor (Table II).

The operative technic has been described in detail elsewhere.[2,3,4,5] Typically, it is done in the cardiac catheterization laboratory where, under local anesthesia, a transverse incision is made over either cephalic vein. A unipolar electrode is inserted through the vein under fluoroscopic control into a secure position at the apex of the right ventricle. Thereafter, the stimulation threshold is measured with an external pulse generator to confirm the satisfactory position. We will not accept a threshold of above 0.9 to 1.0 milliamperes. The catheter electrode is then fixed in place in the vein with a ligature, and a Silastic® flange is affixed to the lead just as it emerges from the vein; this is sutured down to the underlying fascia. The pacemaker is then attached to the electrode and placed in a subcutaneous pocket overlying the pectoralis major fascia. The wound is closed and the patient returned to his room. Usually patients are up and about the afternoon of surgery and within a few days are ready for discharge.

TABLE I

MORBIDITY AND DEATH FOLLOWING PACEMAKER IMPLANTATION

	Complete Operations	Number of Patients	Number of Deaths	Mean Post-operative Hospital Stay days
Transthoracic	74	63*	2 (3%)	14
Transdiaphragmatic	11	11**	0	11
Transvenous	161	143***	1 (0.5%)	7
Totals	246	217††	3 (1.5%)	

*Including 1 converted from transvenous.
**Including 4 converted from transthoracic.
***Including 12 converted from transthoracic.
††17 patients counted twice.

Complications with this method used to be

* This work is written by Doctors V. Parsonnet, I. R. Zucker, L. Gilbert, J. Alpert, E. L. Rothfeld, D. K. Brief, A. Bernstein, and G. H. Myers. It comes from the Newark Beth Israel Institute and was supported, in part, by grants from the Essex County and New Jersey Heart Associations, the John A. Hartford Foundation, Inc., and the Newark Beth Israel Hospital Research Foundation.

TABLE II
COMPLICATIONS

	Number in Last 50 cases	Number in Previous 50 cases	How to Avoid Complications
Component failure or electrical interference	2	6	Use a good pacemaker. Check output before insertion.
Broken lead	0	1	Use cephalic vein. Implant pacemaker in pectoral area. Handle wires with care. Do not use makeshift splices.
Dislodged leads or perforation of myocardium	2	9	Use butterfly flange. Use electrode with "shoulder" at its tip. Leave proper size loop in the atrium.
Threshhold increase	0	2	Correct testing at initial insertion for minimal threshold.
Infection or thrombophlebitis of vein	1	2	No early re-entry into the wound. Pre and postoperative antibiotics. Meticulous sterile technics.
Muscle twitch	1	3	Proper selection of subcutaneous pocket. Suture fixation of pacemaker.
Total	6 (in 5 pts) 10%	23 (in 20 pts) 40%	

frequent, but now they occur in only 10 per cent of cases. (Table II) Except for component and battery failure (which are out of the hands of the surgeon), complications can usually be avoided by proper attention to detail. Broken leads can be prevented by delicate handling of the electrodes, and by placing the pulse generator in the pectoral position where the chest cage splints the wires so that they do not flex with the usual bodily movements. We do not use the external jugular vein for insertion of such wires, because the wire must then cross the clavicle where it is vulnerable to movement.

Dislodgement of an electrode usually occurs when the lead wire in the atrium is too long or too short, when the tip has not been properly entrapped in the trabeculae of the right ventricle, and when the butterfly flange is not used. The present lead also has a small flange of Silastic® at the tip near the electrode which helps hold it in position in the heart.

A rise of stimulus threshold above the output of the pacemaker occurs when there is infection of the implant site, or if the initial electrical position of the electrode was unsatisfactory. We now do careful testing of thresholds with standard engineering oscilloscopes and external pulse generators at the time of initial insertion of the electrode. Since we have done this, there has been only one instance of pacing failure from high threshold.

Preliminary Transvenous Pacing

For some time we have advocated temporary external transvenous pacing[6] of the heart in all cases of heart block. This is done by inserting a bipolar electrode through a suitable vein (external jugular, brachial, or saphenous) under fluoroscopic control into the outflow tract or apex of the ventricle. Pacing is then maintained until the permanent pacemaker is inserted.

We now believe that this should be done in most patients who are candidates for insertion of a permanent pacemaker, with the exception of those who have had chronic heart block for more than a few months and who do not have congestive heart failure, debilitating medical disease, or Stokes-Adams seizures. Such patients are relatively rare, and therefore insertion of a permanent pacemaker without preliminary transvenous pacing has been done in only a few patients.

Temporary transvenous pacing protects the patient during the initial medical workup, and it is rapidly performed even in the most critical emergency situations. Moreover, it provides control of the heart rate during the permanent pacemaker implantation when even the infiltration of local anesthesia may cause slowing of the heart and cardiac arrest.

Pacing Mode

Three types of pacemakers are available—fixed rate, synchronous, and standby (Table III). Fixed rate pacing has the advantage of being well tested by time; it is reliable and the units are likely to last three or more years. Unfortunately, because patients develop competition between idiocardiac beats and the pacemaker in 30 to 50 per cent of the

TABLE III
PACING MODE

	For	Against
Fixed	Time Tested Long Life (3 years)	Competition Cardiac output not optimal
Synchronous	Full benefit of synchronization and cardiac output No competition External control or rate	Extra electrodes Sensitive to "noise" Shorter life (2 years)
Standby	No competition External control of rate	Shorter life (2 years) Sensitive to "noise"

cases, ventricular fibrillation may result from inadvertent stimulation of the heart during the vulnerable period. For this reason, fixed rate pacing is dangerous in such individuals.

The synchronous pacemaker (now available for transvenous use) provides the patient with the full benefit of synchronous contraction of the atria and ventricles and an optimum cardiac output at various atrial rates. It also prevents competition between the idiocardiac contractions and the stimulus of the pacemaker. Unfortunately, it has a shorter life expectancy than the fixed rate unit, and it requires two electrodes. Its sensing circuit may, at times, be susceptible to external electrical interference and thereby produce accidental fast pacing rates.

The standby pacemaker also has a shorter life expectancy than a fixed rate pacemaker, but has the advantage of shutting itself off when it is not required. It will not compete with idiocardiac contractions, but it may be sensitive to electrical interference. Only one electrode is required in this pacemaker and for this reason it may be preferable to other devices.

We now use standby pacemakers in almost all patients. Selection of fixed rate pacemakers is confined to patients who have demonstrated no evidence of competition during previous pacemaking experience. In such individuals, when their fixed rate pacemakers require changing, we use another fixed rate pacemaker. Synchronous pacemakers have been used only in the young patient who needs maximum cardiac output, and in those patients with chronic heart failure, when the full increment of cardiac output achieved by atrial synchrony is required. In all other situations (that is, for most individuals) standby pacemakers have been used.

Standby Pacemaking

It has been maintained by some that there is no danger to the patient when competition between idiocardiac contractions and a fixed rate pacemaker occur. In fact, in laboratory studies we have been unable to demonstrate significant arrhythmias from competitive pacing unless the heart is altered in some way by various drugs and anoxia.[17] Although at most times the paced human heart may be relatively insensitive to competition, the fibrillation threshold may be lowered by anoxia, digitalis toxicity, electrolyte imbalance, and other factors. In these situations, competition can become dangerous. In fact, repetitive rhythms[8] and ventricular fibrillation[9] have been documented in humans following stimulation of the heart in its vulnerable period by a standard pacemaker stimulus.[10]

Almost every report of studies throughout the world[12] of large groups of patients with pacemakers has mentioned a few unaccountable sudden deaths.[13] Similarly, sudden deaths have occurred in our patients. Table IV indicates that nine sudden deaths in a series of 200 patients occurred in patients with fixed rate pacemakers and competition. One patient with a fixed rate pacemaker (but without known competition) also died suddenly. Although no competition had been demonstrated in this patient, it is conceivable that competition did occur at irregular intervals. In comparison, *there were no sudden deaths*

in the entire group of patients with standby pacemakers, even though these units have been in use for more than two years. In fact, there have been only two deaths in this group: one post-operatively from a pulmonary embolus, and another from uremia and congestive heart failure.

TABLE IV

SUDDEN DEATHS

	Fixed Rate		Standby	
	Number of Patients	Number of Deaths	Number of Patients	Number of Deaths
Competition	24	9	65*	0
No competition	62	1	21	0
Totals	86	10**	86	0

*Including 2 Atricor (synchronous pacemakers).
**28 patients died of other causes.

Choice of Pacemaker Model

It is not possible to compare the pacemakers of various manufacturers on the basis of personal experience. We have used most of the popular American made models, and have gradually settled on the Cordis® pacemakers because they have certain features which we prefer. The Cordis® lead and electrode is made of Elgiloy® that has remarkable fatigue resistance. Because it can be used only as a cathode, a unipolar system is necessary. The Cordis Corporation is the only company in the country that makes such a unipolar system, although all can be adapted to this. In addition, they make all three models of pacemakers: fixed rate, synchronous, and standby. These have proved themselves to be reliable instruments and there have been few component or battery failures in our hands. In fairness, it should be stated that our experience with both Electrodyne® and Medtronics® pacemakers was also quite good.

Indications

To recommend that a patient have a permanent pacemaker implanted, one must be certain that the technic is safe, that the results are good, and that complications are few. Actually, implantation of a permanent pacemaker has proved to be a reliable procedure with little morbidity and no mortality. Therefore, indications for its use can be quite liberal. At first, only patients with complete heart block and Stokes-Adam seizures refractory to medical therapy were accepted for pacemaker implantation. Now however, indications have become quite broad. Since standby and synchronous pacing are available, pacemakers can be inserted in patients with intermittent heart block, sinus arrest, atrial fibrillation with block, and in certain chaotic arrythmias, especially those triggered by brachycardia.

Patients may survive many years with complete heart block while under medical therapy alone. An analysis, however, of the mechanism of demise of such patients reveals that they usually die suddenly, presumably from their first Stokes-Adams attack. Moreover, it has been our experience that such patients, who finally had a pacemaker implanted, uniformly noticed improvement in well-being and vitality, and decrease in fatigue. There is no logical reason today for the continuation of medical therapy in such individuals.

Follow-up

The primary problem faced by all patients with permanent pacemaker is to know when the pacemaker requires changing. In the past, this has been determined either by waiting until the patient shows signs of intermittent pacing, or by choosing a certain arbitrary age of the pacemaker beyond which it would be unsafe to continue its use.

We have shown that measurement of the expanded electric artifact from the pacemaker will yield significant information about the expected longevity of the pacemaker.[15] Important parameters include the pulse interval (or rate), the height and duration of the artifact, and its contour. We have found it useful to measure these variables in a pacemaker "center" where the patients appear at set intervals for appropriate testing. With this method, impending pacemaker failure can be predicted in 50 to 75 per cent of cases. Moreover, if patients had been seen at frequent intervals (for example once a month instead of once every six months), many more accurate predictions would have been obtained. Presently it is hoped to use a computer to

facilitate this type of analysis so that patients can indeed be seen as frequently as necessary for tests.

The Future

The batteries of existing pacemakers last from two to four years depending upon the model. Those with "sensing circuits," such as the synchronous and standby pacemakers, do not last as long as fixed rate units. The longest life of a pacemaker in this series was 47 months. Permanent pacemaker implantation would become a still more acceptable procedure if the batteries could be changed at less frequent intervals, such as 10 years or longer. It appears certain that existing transvenous wires will last at least that long, because, even after three years, wire fractures are rarely seen.

The most important advance for the future will be new power sources, or methods of decreasing the power requirements which would also lengthen the life of existing batteries. Such objectives may be achieved by the use of a new electrode, developed at the Newark Beth Israel Hospital, called a Differential Current-Density Electrode (DCD).[16] This requires one tenth the energy of standard electrodes for stimulation of the heart. It is estimated that it will at least double the life expectancy of existing batteries.

Another approach has been to develop nuclear power sources. Such a device, currently in the prototype stage, is being developed by the Numec-Cordis Companies under a grant from the Atomic Energy Commission. It seems likely that the actual pacemaker will be ready for animal experimentation in the near future, and within a few years will be available for humans. It has an expected life expectancy of at least 10 years, and hopefully may prove to be safe and practical.

Summary and Conclusions

1. Implantable pacemakers are entirely safe, effective, and acceptable devices for the treatment of heart block. Indications for implantation of a pacemaker have broadened to include almost any type of heart block despite the patient's age and the degree of congestive heart failure and debility.

2. Liberalization of the indications for surgery has been brought about by the development of permanent transvenous pacing that can be accomplished under local anesthesia alone, and by the use of standby or synchronous pacemakers that prevent competition between naturally occurring idiocardiac heart beats and the pacemaker.

3. There is little place any longer for the medical management of complete heart block.

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201 Lyons Avenue

The "tranquilizing" drugs have been boons to mentally ill patients. But as with all potent medication, side-effects do occur. Here is a relatively rare one.

Abnormal Lactation Associated With Fluphenazine Enanthate*

Granville L. Jones, M.D./Summit

Recently a new form of a phenothiazine drug has been introduced; fluphenazine enanthate. This is a relatively insoluble form which is absorbed slowly when given by intramuscular injection. Injection every two weeks will, in most instances, maintain a blood level in the effective range. In view of some patients' tendency to omit medication, an injectable "depot" form of this class of drugs offers some real advantages. It is important, however, that troublesome side effects be reported in order that all concerned be aware of the disadvantages as well as advantages. As in the case of the "depot" form of penicillin and other long acting drugs, one can be embarrassed by the inability to undo what has been done.

One of the side effects of phenothiazine medication is the production of lactation in nonparturient women. Such cases were cited early in the experience with the phenothiazines and have been reported with almost all of the drugs commonly used. Hooper *et al.*[1] found 26 per cent of female patients in a Veterans Administration Hospital receiving tranquilizer medication had developed lactation. They commented that higher dosage seemed to show a stronger tendency to produce galactorrhea. Ordinarily, when this symptom develops one can eliminate it simply by stopping the drug, or reducing the dosage. Since it is not disabling or dangerous, such measures are usually sufficient and no great concern has been felt over its occurrence.

The following case is reported, although admittedly the lactation cannot be attributed with certainty to the use of the enanthate drug.

A 31-year-old married woman had a history of gradual development, over a six months period, of ideas of infidelity, jealousy, and delusions of persecution. She thought the house had been "bugged." She nailed the windows shut, suspected her husband of having an affair with her own mother, and said that the food was being poisoned. She neglected her appearance. Her mood became silly and inappropriate. One day, she slashed her wrists. She was treated for about a week in the psychiatric ward of a general hospital, then was brought to Fair Oaks Hospital in Summit. On admission she was pleasant, neat, cooperative, and spoke freely about her ideas concerning her husband. She gave long circumstantial descriptions of the phenomena which made her suspicious. She was depressed and perplexed. Her affect was somewhat inconsistent. Her sensorium was clear; insight and judgment were defective.

She was a well developed, heathy-appearing young woman with several self inflicted scars on her wrists; a right rectus scar extending down into the groin, and a small right lower quadrant scar from an appendectomy. Neurologic examination was negative. She was menstruating on admission. Urinanalysis was essentially negative; glucose tolerance curve was normal; Hemoglobin was 13 Grams. Blood count and chemistry studies were negative.

The patient was diagnosed schizophrenic reaction, paranoid type. She received flupnenazine hydrochloride, 3 milligrams daily by mouth from July 18 to July 20. On July 20 it was increased to 15 milligrams daily and continued at this level until July 31. On that date she was given a 25 milligram injection of fluphenazine enanthate. On July 23 she complained of some muscular incoordination and was given a subcutaneous injection of 2 milligrams of Benztropine

* This work is from the Fair Oaks Hospital in Summit.

Mesylate® and was started on 2 milligrams of this by mouth the next day. This was continued during her stay in the hospital. Because of the feeling of being "on edge" she was given thioridazine by mouth: 25 milligrams on July 25; 75 milligrams on July 26; 100 milligrams on July 27 through August 2; 200 on August 3; 150 on August 4; and 50 on August 5. On August 2 she began a series of eight unidirectional-unilateral electro-convulsive treatments.

Six days after the injection of the fluphenazine enanthate, milk was discovered in her breasts. Her last pregnancy had terminated in a miscarriage three years prior to her admission. The milk was moderate in amount, there was not much fullness or congestion, and there was no tenderness. She was given methyltestosterone propionate, 25 milligrams twice daily for five doses, with no apparent effect. On August 11, we started diethylstilbestrol, 5 milligrams by mouth three times daily. This was continued until discharge. On August 14 (when the next injection of fluphenazine was due) she began taking haloperidol, 2 milligrams t.i.d., increased to 5 milligrams two days later. The milk gradually declined in amount and on August 24, the day of discharge, was present only in minimal amounts. Aschheim-Zondek test on August 21 was negative.

On discharge the patient was quite free of overt psychotic symptoms, and even had some superficial insight into the unreality of her past experiences. She had busied herself at the hospital in occupational therapy activities, was fairly congenial with the other patients, and was quite anxious to return to her husband and family.

It is not possible to state with certainty that the long acting fluphenazine was responsible for the abnormal lactation. Thioridazine has been frequently observed to produce this side effect and was being administered at the time her symptoms began. However, the total amount of thioridazine was 1200 milligrams spread over a 12 day period, which is certainly not an excessive dosage of this drug. It is likely, therefore, that the injection of fluphenazine at least contributed to the phenomenon with the thioridazine producing an additive effect. In any case, the continuing absorption of the fluphenazine doubtless maintained the endocrine state after the discontinuation of the thioridizine.

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19 Prospect St.

Ultrasonic Fog For Cystic Fibrosis

A Cleveland pediatrics professor suggests that children with cystic fibrosis should sleep in an "ultrasonic-fog" tent all night. This leads to a dramatic improvement in these children whose airways are plugged up by the thick mucus. So says Dr. Leroy Matthews, who is professor of pediatrics at Western Reserve University School of Medicine.

Dr. Matthews said he cares for about 40 patients who take this treatment at home every night. They range in age from 2 to 25 years. The "fog" they breathe as they sleep is the densest ever made in this world. It is procduced by a device called the ultrasonic nebulizer. This uses ultrasonic energy to produce prodigious amounts of extremely tiny water droplets. These droplets penetrate all the way to the outer limits of the lung, and into the entire bronchial tree. The moisture dilutes the mucus characteristic of cystic fibrosis.

Dr. Matthews has made tests which indicate that cold fog made by jets is converted to water vapor in warm air. But ultrasonic fog remains as water droplets all the way to the periphery of the lungs.

Children better survive cystic fibrosis if they are given cold-fog treatments even before they develop breathing problems. Patients of his on such prophylactic cold-fog treatments are still clear of lung diseases, 10 years after their treatments began.

Cysts of the spleen are rarely thought of and even more rarely found. To the meager collection of such cysts in the world literature, two cases are here added.

Cysts Of The Spleen

L. Vincent Strully, M.D. and Robert P. Steinfeld, M.D./Paterson

Review of the literature indicates that 268 cases of cysts of the spleen have been reported to date. Because this is a relatively rare pathologic entity, it seems worthwhile to report two additional cases.

Fowler's classification of primary and secondary or true and false cysts, is quite practical.[5] McClure and Altemeier[1] developed the following more detailed classification:

I. True cysts (lined by specific secreting membrane)

A. Epithelial

1. Dermoid
2. Epidermoid

B. Endothelial

1. Lymphangioma
2. Hemangioma
3. Polycystic disease
4. Some serous cysts

C. Parasitic (lined by protoplasmic matrix containing numerous nuclei)

1. Echinococcus

II. False cysts (no specific secreting lining)

A. Hemorrhagic

B. Serous

C. Inflammatory

1. Acute necrosis from infection
2. Chronic tuberculosis

D. Degenerating liquefaction of infarcted areas (embolism, thrombosis)

Our first patient was a 47-year old woman who complained of sour eructation, heartburn, and vomiting. Two weeks prior to admission she developed a feeling of pressure in the left upper quadrant, associated with chills, fever, and vomiting. When we first saw her, she was an acutely ill, pale, well oriented female in obvious distress. Temperature was 100.8, blood pressure was 148/86, and pulse, 110. In the left upper quadrant was a tender mass extending 3 centimeters below the left costal margin. Barium enema revealed the splenic flexure to be pushed inferiorly. X-rays showed the stomach displaced to the right. Once stabilized, celiotomy revealed a 20 centimeter cyst of the spleen. Splenectomy was done. A serous cyst of the spleen was the pathologic diagnosis.

The second patient was a 32-year old man. On "routine" chest x-ray, we noticed an asymptomatic calcified mass in the left upper quadrant. Physical examination was entirely negative. Diagnostic work-up (including perirenal air studies) was inconclusive. At laparotomy a cyst of the spleen was found. Splenectomy was done. The pathologist's report was a calcified splenic cyst, probably congenital.

McClure and Altemeier[2] point out that more cysts occur in women than in men and that these women are often in the age group from 20 to 50. Cysts, both true and false, have been found in the newborn and in children.

True cysts are lined by specific secreting membranes, epithelial, endothelial or parasitic. Echinococcal cysts of the spleen are by far the most common factor, not only in parasitic cysts of the spleen but in all cysts of the spleen. Hydatid cysts have been reported in the spleen by Fowler[9] but their absolute incidence remains undetermined. Denneen[3] states that true cysts are, in reality, inclusions of peritoneum into the spleen secondary to trauma or possibly inflammation. He labels these "infoliation cysts." They may be single

or multiple, superficial, or deep. They are to be distinguished from the cystic disease of a polycystic spleen or cysts arising from hemangiomata or lymphangioma contained within the spleen. De Lee[4] theorized that true cysts may develop from cellular nests formed under the splenic capsule as a result of abnormal invagination of the perisplenium during fetal life. The cyclical hormonal changes occurring during menstruation and pregnancy alter the size and congestion of the spleen and trauma may be sufficient to induce hematoma or cystic changes during that phase. Fowler[9] found that 80 per cent were large, solitary, unilocular; two-thirds being hemorrhagic and one-third serous.

False cysts contain no specific secretory lining. They occur four times as often as true cysts. Trauma is, perhaps, the one most important factor responsible for the large hemorrhagic or serous cyst. Spontaneous intrasplenic bleeding into the normal spleen may likewise produce cyst formation. Hemorrhagic true cysts are, in contrast, quite rare. When they do occur, the bleeding is generally into pre-existing hemangioma or lymphangiomas of the spleen. The role of infarcted areas from arterial degeneration or occlusion of blood vessels by intimal emboli, with subsequent necrosis of splenic pulp and cyst formation, has been reported by Denneen[3] as another possible etiology of false cysts.

In reviewing various case reports, the following symptoms were reported:

1. *Subjective* — Belching, heartburn, sour eructations, heaviness in the left upper quadrant of the abdomen, vomiting or regurgitation, fullness with meals, sense of downward pressure and dragging.[2,6,8]

2. *Objective* — Bulging of the left upper quadrant; superficial or deep mass in the left upper quadrant of the abdomen, with or without tenderness.

The clinical course varies with the factors of hemorrhage into or infection of the cyst. Hemorrhage causes acute pain and tenderness. Infection adds fever, leukocytosis, and reflex ileus to the symptoms. On the other hand, there may be no symptoms during life and the cyst may be found at laparotomy or autopsy, as an incidental condition. When calcified, the cyst can be seen on routine chest x-ray. An enlarging cyst adds pressure and tenderness to the symptoms. Occasionally, trauma may rupture the cyst.

Diagnosis

X-rays may show displacement of stomach and splenic flexure of colon.[7] Intravenous pyelogram and perirenal air studies can eliminate the kidney and adrenals as causes of a left upper quadrant mass. Islam[6] has reported percutaneous splenic venography as a means of diagnosis. These studies become important when one must consider hydronephrosis, cyst of the tail of the pancreas, retroperitoneal tumors, carcinoma of the splenic flexure of the colon, spontaneous thrombosis of the splenic vein, and infarction of the spleen in the differential diagnosis of left upper quadrant masses. With all these studies, laparotomy may still be the only means of establishing the true diagnosis.

Summary

1. Two patients with cysts of the spleen, one symptomatic, the other discovered on routine x-ray examination of the chest, have been presented.

2. A review of the literature has been presented, as well as the signs and symptoms. We have added 2 cases to the 268 cases already reported in the literature.

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646 Broadway

Many believe that the prime factors in schizophrenia are biochemical, not psychodynamic. Here are some cases which suggest cortico-steriod factors.

Bee Stings And Schizophrenia

Julio del Castillo, M.D./Trenton

In the fall of 1966, I assisted in a psychiatric case presentation about a man of 45. He had a history of previous mental hospitalizations. Once he had been diagnosed as schizophrenic, once as suffering from an anxiety attack. He was a beekeeper by profession. His family was considered normal, except for a son, aged 8, who, two years ago, suddenly stopped talking. From then on, the boy had been mute for long periods. His teacher couldn't get through to him, and he was placed in a special school, where he has been ever since. Our patient was a diabetic, under control with tolbutamide.

While the other participants in this presentation (psychiatrists, physicians, a psychologist, and a social worker) were offering a dynamic formulation to account for the patient's illness, my own thoughts went back to my childhood and adolescent years when I had a few bee hives as a hobby. I remembered how often I was asked by someone to let him get near my hives because he felt that he could be "cured" of aches and pains by submitting to a bee sting. I have known patients to say: "Doctor, my rheumatism does not get cured with pills; I am going to the country to have the bees sting me." I assumed at that time that the "curative property of bee stings" was a superstition. I never thought seriously about it.

During our case presentation, I told my associates about my past experiences with bees and recall my observation: "If this man is a beekeeper, probably he was often stung by his bees. If those patients who asserted relief of arthritis after bee stings, were accurate, it is possible that bee venom may have some similarity with cortisone and its analogues; and therefore is able to produce the side effects of the adrenocortical steroids." I pointed out that this patient also suffered from diabetes and acne. Everyone in the staff room was very amused. None of them had heard of any "curative" properties of bee venom. So we returned to "dynamic" formulations as the explanation of the patient's mental illness.

In the spring of 1967 I saw a patient who appeared very anxious, tense, and depressed, and whose face was familiar to me because of his regular visits to the clinic and his obvious mental distress. He complained about deep feelings of depression and anxiety. He insisted that he did not get any benefit from his visits to the clinic or his medication. During the interview he mentioned that he was a beekeeper. I reacted with great interest and soon discovered that he was the patient discussed in the case presentation above.

Progress notes showed a progressive worsening of the patient's condition. His physician had made multiple efforts for improvement and had constantly changed the patient's medication or the dosage; but all results were poor. I requested the Clinic Director to assign this patient to me and also to change the patient's status in the clinic from that of a medication patient (in which case patients are seen briefly) to a psychotherapy patient, which would give the patient the benefit of a 50-minute interview once a week, or more

often if necessary. Accordingly, the patient was assigned to me. I then prescribed chlordiazepoxide (Librium®) 25 milligrams three times a day; other tranquilizing medications were discontinued. He was instructed to stay away from the bees until the following week. On his next visit, he showed a remarkable improvement. He was more calm and relaxed. His urine showed no sugar. He stated that he took the chlordiazepoxide only twice a day. He told me that he had stayed away from the bees, but that he would soon have to return to his job.

He was advised to keep away from the bees for at least a couple of weeks more, told to test his urine for sugar daily and to report if the test was positive at any time. Blood sugar two hours after breakfast was indicated for two and five days later respectively. He was instructed to discontinue all medications, including the tolbutamide for his diabetes. The patient did not appear prepared to receive so many orders. He did not want to give up the tranquilizer, asking me vehemently for a supply of the medication. He insisted that he could not sleep well because he had abandoned his bees for a week, and now I was asking him to prolong this. I agreed that he might take the chlordiazepoxide at intervals up to four times a day but to make every effort not to take any. A vitamin preparation was also prescribed, as the patient complained of poor appetite and diet for a long time.

His blood sugar tests showed normal results in spite of the fact that he had not taken the tolbutamide. Now he insisted that he was going to return to his bees. He was an employee at a farm with several bee hives. The owner had come to the conclusion that it was *my* opinion that "the bees make him diabetic and insane." They had consulted another physician, who had made a fasting blood sugar which showed normal results. (Patient at no time would reveal the name of this friend, nor the physician.) He continued his weekly visits to the clinic and maintained his improvement. He did not show any overt psychotic symptoms, nor was he depressed. However, the "peculiarity" of his thoughts remained such as to be considered sequelae of a long standing schizophrenic illness. He related ambivalent feelings toward others, especially his family. He talked about his religious beliefs, expressing his idea of the non-existence of God; then contradicted himself by saying that he prayed every day for God's help. He had been aware of these contradictory feelings. In spite of his improvement, patient remained with a deep-seated feeling of inadequacy, saying he felt unable to face life.

I had been informed by Roche Laboratories on June 14, 1967, that: "To date, we have no studies determining the action of Librium® on the pancreatic secretions. However, in a study by Zbinden, autopsy data on sixteen rats who were treated with Librium for one year revealed no gross or microscopic pathologic changes in the organs and tissues."

For sometime prior to his first admission, this patient took care of bees, collecting honey from several farms scattered in various and distant places. Whenever he found hives with bees suffering from diseases (especially "foul brood") he transferred them to other places far from the healthy ones. At the back of his house he usually had a few hives with diseased bees. He treated the diseased bees with antibiotics and chemotherapeutic agents mixed with sugar, scattering this at the top of the bee box. The diseased bees were the ones which very frequently stung the patient, as their hives required much manipulation.

In discussing his "emotionally sick" son, the patient said that he was the favorite, or "Papa's boy." The boy liked the forest, was very fond of bees, and always helped his father with the care of the diseased bees, doing so even when he went home to visit once a month. The boy was many times stung by diseased bees before becoming "emotionally sick," he still was stung occasionally during his visits at home.

Since I began treating this patient reported on here, I have been asking all schizophrenic patients about their exposure to bees. It ap-

pears difficult to find someone who has *not* been stung by bees at one time or another, even among normal individuals. However, I will cite only two cases:

(1) A 28 year-old female was diagnosed as schizophrenic during her admission to the state hospital. When I asked, she reported having been stung by many bees many times during her childhood. There was a bee hive at the back yard of her house when she was a child.

(2) A male, age 33 recently sought psychiatric help in our clinic. His chief complaint was lack of feeling toward his wife and inability to express himself. He exhibited obvious blocking in the psychiatric interviews. Two years ago, while he was fixing the roof of his house, he was stung many times by bees who were living in a hole in the roof.

Many physicians have pointed out a relationship between schizophrenia and hyperfunction of the adrenal cortex. Data about steroid-induced psychosis are abundant.

For many years physicians from numerous parts of the world (including the United States) have found anti-inflammatory properties in bee venom. It has been used to treat many types of arthritis. Reported indications, contraindications, and side effects of bee venom therapy are similar to those of steroid therapy, except that I have been unable to find psychosis due to bee venom therapy. I think this is because healthy bees were used. Little is known about the nature of bee venom. It certainly includes several toxic constituents. I think bee venom contains variable amounts of substances that are in close relation to the glucocorticoids and analogues.

Conclusion

I agree with many investigators that schizophrenia may be chemically caused, probably by the elaboration of some substance produced by a hyperfunctioning adrenal cortex of the individual himself. I suggest that schizophrenia can also be produced by the stings of diseased bees, due to some impurity of the bee venom. The individual's own physiologic defenses or sensitivities must play a role in relation to such "schizophrenic" conditions. It also appears that the individual must be stung by diseased bees a great number of times and repeatedly. Rashkis and Harris[4] say that "the mechanism of psychosis probably involves production of an abnormal hormone by the adrenal cortex when the patient is under organismic stress." I think that a similar "abnormal hormone" can be isolated from diseased bees.

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The New Jersey State Hospital

1968 Annual Meeting

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Haddon Hall, Atlantic City

Manufacture of pesticides is one of our state's major industries. Doctors ought to know that pesticides may be health hazards, and that they may lead to silent people as well as to a silent spring.

Parathion Poisoning In Children*

Two Recoveries and One Fatality

Stanley Bernstein, M.D./Bridgeton, John H. Gould, M.D./Shiloh, and Arthur DePalma, M.D./Trenton†

Parathion, an organic phosphate pesticide, has been used extensively during the last 20 years in agriculture and in many other pest control operations. *Accidental exposure to parathion has been a major cause of fatal poisonings throughout the world.* In our own hemisphere, recent tragic deaths of children in Mexico, Florida, and Colombia have brought the dangers of misuse of parathion into the national spotlight.

Parathion was first used commercially in this country in 1948, although it had been developed during World War II by the Germans for use in gas warfare. The formula was discovered by British and American Intelligence teams after the war.[1] Organic phosphates in general exert their toxic effect on man by inhibiting the enzyme cholinesterase, so that large amounts of acetylcholine accumulate at the nerve endings, with continuing stimulation at the synaptic junction.

The parasympathetic nervous system is particularly affected, and many of the symptoms of parathion intoxication are secondary to overactivity of the parasympathetic system, in addition to an increase in nerve impulse activity in general. Evidences of poisoning may include headache, giddiness, anxiety, blurred vision, weakness, nausea, cramps, diarrhea, discomfort in the chest, sweating, miosis, tearing, salivation and other excessive respiratory tract secretion, vomiting, cyanosis, papilledema, muscle twitching, convulsions, coma, loss of reflexes, and loss of sphincter control.[2]

Treatment of parathion poisoning includes:

1. atropine (1 to 2 milligrams) or (0.015 to 0.05 milligrams per kilogram in children) if symptoms appear, and continued doses every hour up to 50 milligrams in a day, if excessive secretions occur; and

2. 2-PAM or Protopam® (1 Gram), which acts by freeing the cholinesterase from its inhibitor.[3] Give 15 milligrams per kilogram in children, slowly, intravenously; and

3. decontamination of the skin and emptying of the stomach; plus

4. symptomatic treatment.

In very severe cases, artificial respiration may have to be administered[2] and the atropine increased to 4 milligrams intravenously as soon as cyanosis is overcome, and repeated at

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* This work is from the Bridgeton Hospital, Bridgeton, New Jersey (Drs. Bernstein and Gould) and the Community Pesticide Program, New Jersey State Department of Health, Trenton, and is supported by the United States Public Health Service, under Contract No. PH 86-65-34. Dr. DePalma is a commissioned officer of the U.S.P.H.S., assigned to the National Communicable Disease Center. Reprints are available from the Pesticide Project, State Health Department, Box 1540, Trenton 08925.

† Mr. Peace Paubionsky, Mr. George L. Bever, Jr., and Mr. Stephen E. Killiany, Jr., carried out the special pesticide chemical and biochemical testing. Gerald S. Eichner, M.D., supervised the clinical testing and performed the autopsy. We also gratefully acknowledge the advice and assistance received from Mr. W. F. Carey and his associates from the Department of Agricultural Chemistry in the College of Agriculture and Environmental Science, Rutgers University.

5 minute intervals until atropinization occurs.[4]

Here are case reports of accidental parathion poisoning in three children:

On July 10, 1967, three children were poisoned with parathion. They were part of a Puerto Rican family of ten, who had moved into the migrant quarters of a southern New Jersey farm the previous day. The building which they moved into was reported to have been sprayed previously with a spray can to rid the house of flies.

On the afternoon of July 10, at 4 p.m., two twin girls (A and B), age 2, and their three-year-old sister (C) found a spray can underneath the outside steps. In the presence of their nine-year-old brother, they proceeded to spray each other while they played, then licked the spray from their hands. At 6 p.m. two of the children (B, age 2, and C, age 3) felt ill and developed a cough. At 7 p.m. the mother arrived home and frantically summoned help, as the two girls continued to deteriorate. A few minutes later, when they were seen by a physician. B was almost moribund. She was dyspneic, cyanotic, and had a fever of 101. She coughed frequently, with rales throughout her lungs, and appeared to have acute pneumonia. C, however, had only a few wheezes and a wet cough. The two sisters were immediately admitted to Bridgeton Hospital, where B was given Decadron® intramuscularly, an aminophylline suppository, intramuscular Crysticillin,® put into an oxygen tent, and given intravenous fluids. A chest x-ray revealed markings consistent with diffuse interstitial pneumonia or edema, and the white cell count was 13,150; 74 per cent neutrophils; and 24 per cent lymphocytes. Her condition continued to be critical over the next few hours. She developed limp musculature with twitching, miosis, nystagmus, excessive salivation and signs of pulmonary edema. She appeared to be in shock, with a cold sweat, pulse of 160 and tachypnea of 48.

C, on admission, had a white cell count of 6,200, with 58 per cent neutrophils, 11 per cent band cells, and 31 per cent lymphocytes. As the evening progressed, she began to develop muscular twitching and hyporeflexia. A lumbar puncture was then performed. The opening pressure was 342 mm of water and clear fluid, containing one per ccm WBC. The sugar was 85 mg per cent and the protein 26 mg per cent.

At this point, the situation was reappraised, and a chemical poisoning was suspected. The parents were questioned (in Spanish) and two sources of possible poisoning were suggested: (1) tomatoes in the vicinity had been sprayed with Guthion® three days previously. Later analyses showed no Guthion® residues; (2) the spray can incident was then revealed. The physician in charge of the poison control center of the hospital was made aware of the situation, and agreed with the possibility of organic phosphate poisoning.

At 10:30 p.m. (six hours after exposure), both girls were given 0.2 mg atropine intramuscularly and 500 mg 2-PAM® intravenously. The atropine was repeated every 30 minutes for four doses.

At 11 p.m., A, the other twin who had been asymptomatic, was admitted for observation. Within 15 minutes after admission, she developed a cough, dyspnea and cyanosis. Immediately, she was given 0.2 mg atropine intramuscularly, and this was repeated every 15 minutes for three doses; 500 mg 2-PAM® was injected slowly, intravenously. She responded slightly, but at 2 a.m. her airway became obstructed. A tracheostomy was done; she died 15 minutes later in spite of the rapid intervention.

By 3:30 a.m. the other two girls (B and C) had become alert and asymptomatic and showed the flushing of atropinism. The following morning, 15 hours after admission, B was given another 0.2 mg of atropine to reverse a mild exacerbation of symptoms. Except for this episode, the remainder of the hospital course was uneventful, and the children were discharged one week after admission.

The contents of the spray can were analyzed. It contained 2½ per cent parathion, which apparently had been added to a common household insecticide. Biochemical studies were done on B and C. Table I shows the RBC and plasma cholinesterase determinations. The normal range in our laboratory for RBC chlorinesterase is 0.6-0.95 Michel units, and 0.7-1.2 Michel units for plasma cholinesterase.

TABLE I

BLOOD CHOLINESTERASE
(Michel Units), B and C
(determinations after treatment with 2-PAM)

	Erythrocytes [Normal 0.6—0.95]	Plasma [Normal 0.7—1.2]
Patient C		
7–11–67	0.47	0.34
7–12–67	0.51	0.56
7–14–67	0.53	0.49
7–17–67	0.49	0.87
Patient B		
7–11–67	0.48	0,44
7–12–67	0.39	0.37
7–14–67	0.98	0.60
7–17–67	0.53	0.99

Table II shows the results of parathion determinations in the patients' blood. It must be emphasized, however, that parathion is labile and is quickly oxidized in the body to paraoxon, which is also a potent cholinesterase inhibitor. It is a possibility even, that this oxidation product is actually the cholinesterase inhibitor rather than parathion, but this remains to be proved. These determinations were done by gas chromatography, and it is possible that paraoxon was the predominant moiety which was measured, although we speak in terms of measuring parathion.

Table II

BLOOD LEVELS OF PARATHION, B AND C

Patient C	
7–11–67	31 ppb
7–12–67	30 "
7–14–67	3 "
7–17–67	2 "
Patient B	
7–11–67	77 ppb
7–12–67	64 "
7–14–67	16 "
7–17–67	10 "

Table III shows the results of para-nitrophenol in the urine of the two girls. The values of July 12 show the results of several different urine samples. In the Pesticide Laboratory in Trenton, normal controls have a value of 0.2 parts per million (ppm).

Table III

URINE PARA-NITROPHENOL, B AND C IN PPM

[Normal— 0.2]

Specific Gravity	Patient C (ppm)	
1.031	3.6	7–11–67
1.021	2.8	7–12–67
1.011	1.7	
1.013	5.4	
1.014	4.9	
1.030	0.5	7–14–67
0.028	0.2	7–17–67
	Patient B	
Specific Gravity	(ppm]	
1.021	1.4	7–11–67
1.015	1.0	7–12–67
1.006	0.7	
1.001	0.8	
1.005	0.4	
1.026	0.6	7–14–67
1.029	0.3	7–17–67

Blood and tissue were analyzed for parathion and urine was analyzed for para-nitrophenol from the fatal case. Cholinesterase determinations from two blood samples taken at autopsy showed 0.47 and 0.58 Michel units for the red cells, and 0.38 and 0.36 Michel units for plasma. There were 9.6 ppm para-nitrophenol from a bladder aspirate at autopsy. Plasma from heart blood contained four hundred thirty-eight parts per billion (ppb) of parathion. This level may have been excessively high due to tissue contamination, however.

Table IV lists the parathion in parts per million (ppm) found in the tissues of A by the Pesticide Laboratory in the New Jersey Department of Health and the Toxicology Laboratory of the U.S. Public Health Service in Atlanta, Georgia. The amounts of parathion residues in the tissues are very small indeed. Both laboratories are in agreement that a higher residue was found in the adipose tissues.

Table IV

PARATHION RESIDUES IN SEVERAL TISSUES of Patient A

	Parts per Million	
	New Jersey**	Atlanta††
Gonad	Trace	0.088
Subcutaneous Adipose	0.450	0.108
Omental Adipose	0.788	0.325
Kidney	0.064	Neg.
Liver	0.006	Neg.

At the autopsy on A, the microscopic sections of the lungs revealed massive edema, congestion and diffuse consolidation of alveoli by neutrophils and lymphocytes. Sections of cerebrum, cerebellum and brainstem showed generalized vascular congestion. There was slight to moderate hemorrhage in the perivascular spaces of the medulla.

It is impossible to measure the cholinesterase at the synapse, but red blood cell and plasma cholinesterase have been found to be good indicators of the cholinesterase in the nervous system. Although Sumerford *et al*[5] found cases of characteristic illness which occurred in the presence of normal cholinesterase values, there were no severe cases of poisoning among them. On the other hand, a day or two after an acute episode of poisoning has been treated and the patient is asymptomatic, the cholinesterase may be lower than before treatment was begun. The explanation of why a patient may be feeling well in the presence of a very low cholinesterase is not apparent.

Cholinesterase values are low in our cases, except for the 0.98 red blood cell cholinesterase

** These determinations were made in the Pesticide Laboratory, Community Pesticides Program, New Jersey Department of Health, Trenton.

†† These determinations were made in the Toxicology Laboratory of the Pesticides Program, NCDC, PHS, Atlanta, Georgia.

value for B which is exceptionally and unexplainably high. They are not, however, as low as might be expected from such severe poisoning. This can be explained by the fact that the three girls had been treated with 2-PAM® the evening of admission, and the blood was drawn for cholinesterase determinations the following day. Two of the patients were asymptomatic at that time, and the deceased girl had been treated with 2-PAM® almost three hours before she died. Funkes[6] reports a case of not only dramatic chemical response to 2-PAM® but also a rapid rise in the cholinesterase levels. Quimby *et al*[7,8] report at least seven cases where the cholinesterase was reactivated from 25 to, possibly, 100 per cent after 2-PAM® administration. Also it can be noted from Table I that after one week the plasma cholinesterase was much higher than the red blood cell cholinesterase. This is because red cells usually take longer to be regenerated.

Elliott *et al*[9] described another method of determining exposure to parathion by measuring the para-nitrophenol (PNP) moiety of the breakdown product in the urine. Cholinesterase and PNP measurements are both ways of monitoring exposure to parathion, but PNP levels may be interpreted as a measure of the quantity of parathion which has actually entered and has circulated through the body, while the cholinesterase determination measures the pharmacologic effect caused by the parathion in the body. Detectable levels of PNP may be found without a change in the cholinesterase, but usually with a urinary concentration of 2 ppm or more the cholinesterase will be decreased.[10]

The highest PNP found among our cases was 9.6 ppm taken from a bladder aspiration of A at autopsy. Davis[11] found a range of 2.4 to 122 ppm among 14 fatal cases of parathion poisoning, and, in a nonfatal series, the range was from 0.7 to 22 ppm of PNP. In our cases, by 48 hours, most of the PNP was gone from the urine, as seen in Table III.

Another interesting laboratory aspect of this case is that parathion (or paraoxon) was found in the blood of all three patients, and blood and tissues of the deceased girl. Recently, others have found organic phosphate levels in the blood and tissues in similar cases.[12] The possibility cannot be definitely ruled out that a contaminant is being measured; but the diminution of plasma levels of parathion throughout the hospital course, as seen in Table II, is against this.

These cases clinically manifest the rapid response that most parathion-poisoned patients have with atropine and 2-PAM® therapy. Death,[4] when it does occur, as in the case of A, is usually due to interference with respiration by (1) bronchial constriction, (2) excessive secretions, (3) respiratory muscle paralysis, or (4) failure of the respiratory center.

The child who died was asymptomatic longer than the other two. Then her condition suddenly deteriorated until death. The children did receive varying exposures from ingestion, inhalation, and cutaneous sources. There was a twentyfold variation in the dermal absorption of parathion in rabbits in one experiment,[13] and it may be just as likely that absorption varies in humans also, from the intestinal tract as well as the skin.

The signs and symptoms of parathion and other organic phosphate poisoning in general are rapid in onset, occurring within a few hours, and deaths have occurred in five minutes or less after ingestion of large doses.[2] Actually, if symptoms have not occurred within twelve hours of exposure, another etiology should be suspected. Thus, it is essential and lifesaving that appropriate treatment be rendered *immediately* upon even the slightest suspicion of organic phosphate poisoning. Atropine toxicity is usually no problem, even in the recommended dosages, if the diagnosis of intoxication is in error. But, procrastination may be fatal.

Summary

Three cases of acute accidental parathion poisoning are presented, of which one terminated fatally. The similarity of the presenting

symptoms and signs to acute bronchitis or pneumonia initially led to a misdiagnosis. Probing for an accurate history, appreciation of the explosiveness of the onset, together with recognition of signs and symptoms (particularly muscular twitching), characteristic of cholinesterase inhibition, led to the diagnosis of parathion poisoning, and this was confirmed by laboratory findings. The clinical response of two of the patients to atropine and 2-PAM® was dramatic. The relatively high cholinesterase values, in light of the severe poisoning, may be due to 2-PAM® treatment. PNP levels in the urine were elevated initially but declined rapidly. Parathion (or paraoxon) levels in the blood also decreased steadily with time. The major pathological findings at autopsy of the fatal case were pulmonary congestion, consolidation, and edema.

The danger of pesticide-contaiminated containers being left where children may find them is emphasized. Early and accurate diagnosis and rapid and appropriate treatment are essential to the preservation of life.

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61 North Pearl Street

Shoulder Lap Belts

All 1968 automobiles, built after January 1, 1968, will be equipped with front seat shoulder belts.

Federal Highway Administrator Lowell K. Birdwell reports that an extensive study involving government agencies, auto manufacturers, and research experts has confirmed the benefits of shoulder belts. The shoulder-lap belt combination can reduce the incidence of fatal injury in auto crashes by as much as 83 per cent.

The AMA Committee on Automotive Safety has long proposed a shoulder-lap system. In April 1967, it presented a "priority for vehicle safety" to the Automobile Manufacturers Association, part of which asked for an overall seat design development to include a lap belt, upper torso restraint, and adequate head protection.

An interesting sidelight to the subject concerns the safety of pregnant women while traveling in an automobile. The AMA Committee believes that a pregnant woman should always use an automobile seat belt and shoulder belt, and that both she and the fetus are safer than without such protection, provided the belt across the lap is worn as low on the pelvis as possible.

Dr. Harold A. Finner, chairman of the AMA Committee, urges physicians to spearhead a campaign for using this new protective device.

The antibiotic wonder drugs have not yet licked the infection causing bacterium. Vigilance is the price for reducing hospital infections. And, corny as it sounds, cleanliness is next to Godliness.

Hospital Infection

Thomas K. Rathmell, M.D./Trenton*

The public has always regarded the hospital as a place of cleanliness. Today, however, we know that the hospital is neither aseptic nor antiseptic. The cleanest place in the hospital is probably the central supply room. Here sterile materials are stored, and here is an area not subject to the to-and-fro traffic of the institution. Therefore, relatively low bacterial counts are obtained when this area is sampled.

Some years ago, as a resident in a large hospital, an associate and I were given an Unger transfusion apparatus. We proceeded to utilize it in a direct transfusion on a patient. Within the time required to transfer 150 cubic centimeters of blood, we were faced with a recipient who had acute pulmonary edema, shock, and complained of pain in the right side of her chest. Radiographs following cessation of the transfusion attempt showed the patient to have a radiopaque triangular shadow in the lower lobe of her right lung and a diagnosis of pulmonary infarction was made. Recheck of the blood showed it to be incompatible. The Unger transfusion apparatus which we had used was turned over to a nurse for cleansing. She later informed us that, in forcing solutions through the rubber tube of the apparatus, red desiccated fibrin clots, undoubtedly left from a previous use of this apparatus, were obtained. This experience taught me at an early age that *any apparatus which is reused in a hospital should first be investigated to ascertain the state of cleanliness.* Current publications in the field of anesthesia apparatus, bedside water jugs, and ice chests amply confirm this impression. Disposable materials more than justify their cost.

Some years later, we were culturing a rubber catheter. Much to our surprise, *Brucella abortus* was isolated in pure culture. A farmer with a fever of unknown origin and urinary retention was in the house at the same time. Cultures of *his* urine were positive for *Brucella abortus.* Wondering if this might be a chance observation, an additional catheter was cultured and a similar *Brucella abortus* organism was identified. In that hospital, the genitourinary department was notorious for attempts to sterilize its equipment by immersion in chemical solutions.

As a result of this experience, we became convinced that *sterilization by means of chemical liquids is a farce.* Subsequently, with Ogden,[1] we reported the ineffectiveness of benzalkonium solutions to maintain antisepsis in the treatment of burns. We showed that *staphylococcus aureus* and *pseudomonas aeruginosa* could be isolated from 1 to 750 dilutions of these compounds carried on surgical carts.

A 35-year old woman was hospitalized for elective hysterectomy. She had been given antibiotic medication prior to admission, to increase her resistance to infection at the time of operation. Following surgery, she died of an acute staphylococcic enteritis. It was then determined that the blankets assigned to that room had been simply folded and placed on a shelf. Simpe dusting of the blankets over a

* From the Mercer Hospital in Trenton, where Dr. Rathmell is Director of Laboratories. This paper was presented in part on January 25, 1968 before the Special Liaison Committee on Intra Hospital Infections.

blood plate resulted in many colonies of staphylococcus aureus being recovered in pure culture. This experience taught me that if you are being admitted to a hospital, be especially selective of your quarters. Incidentally, all blankets are now laundered, packed in plastic and returned to storage after each patient use.

Recently, a patient was admitted to a hospital and died within 24 hours. He had refused admission to the hospital four days previously. Death was due to an enterocolitis, subacute type. The organism being *salmonella entiriditis.* This salmonella was isolated from the postmortem heart blood on pure culture and from the bowel. These bacteriologic reports were confirmed by our State Department of Health.

Salmonella have been isolated from fresh eggs and chicken "abattoirs" under government inspection, as well as dyes. These experiences have caused us *to frown on adding raw eggs to milk as a dietary ingredient in the hospital.* The consumption of partly cooked chicken or eggs should be forbidden.

The furor of staphylococcic infections in hospitals is now past; however, we became curious as to what types of infection would be obtained if we were to culture the soles of shoes of visitors to the hospital as well as the shoes of technicians working in the hospital laboratory. The following results were achieved.† Note that the larger number of bacterial isolations came from the technicians' shoes where gamma streptococcus, staphylococcus albus and klebsiella pneumonia organisms were obtained. A case of *klebsiella pneumoniae* was in the intensive care unit at the time that these studies were done. Visitors to the hospital were responsible for a high number of *proteus* isolates as well as for one isolation of *staphylococcus aureus.* When staphylococci are isolated, their coagulase reaction is unimportant. They should be regarded as pathogenic. While only ten individuals were cultured in each group, the sample leads us to wonder if it might not be advisable to require hospital personnel to wear protective covering over their shoes and to have this changed daily. Hospital personnel can carry infective organisms about the institution, if such organisms are brought in by the patient. There is also a question as to the cleanliness of the hospital floors. Certainly, a hospital with terrazzo floors would be easier to clean than would a floor covered with vinyl material. We abhor the massaging of dirt into floors by polishing brushes. We must appreciate that the bacterial flora of a hospital is in a state of constant agitation. Our efforts should be directed toward minimizing, dampening, and inhibiting the circulating agents of disease.

SHOE CULTURE

Organism	Technicians	Visitors
Gamma Strep.	2	0
Staph. Albus	5	0
Aerobacter	1	3
Proteus	5	4
Klebsiella Pneum. (ICU)	1	0
Pseudomonas Aerug.	1	1
E. Coli	1	0
Staph. Aureus	0	1
B. Subtilis	0	3
Totals	16	12

Summary

Inasmuch as hospitals are in a process of continuous inoculation with infective organisms (obtained from admitted patients), measures for cleanliness and to combat the spread of infectious organisms throughout the institution must be maintained at a high level. These activities must be continuous and persistent. They must be vigorously prosecuted if the patient is to have the benefit of a maximum opportunity to overcome his disease. In the hospital, there is no substitute for soap, water, and elbow grease. Such a program will achieve cleanliness, which is absolutely essential to antisepsis.

Citation

1. Rathmell, T. and Ogden, A.: Journal of the American Medical Association, 193:978 (September 13, 1965)

† See tabulation

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Dr. Cohen here proposes a systematic and objective check-list for appraising pulmonary disability.

Chronic Bronchopulmonary Disease and the Disability Decision*

Burton Marcus Cohen, M.D./Elizabeth

Chronic obstructive ventilatory disease, like coronary atherosclerosis, has become a "modern epidemic" with implications at all levels of medical awareness. During a recent year, patients with asthma, chronic bronchitis and diffuse obstructive pulmonary emphysema (the most important of the expiratory airflow disorders) paid nearly 50,000,000 visits to their doctors.[1] General practitioners now devote an equal amount of their professional day to respiratory and to cardiovascular problems.[2] Chronic respiratory diseases account for more than 83,000 deaths yearly in this country.[3] Over the age of 45, their toll is more than double that from diabetes and one and one-half times that from accidents. These may be conservative figures, since the official "direct respiratory" deaths have been estimated at only two-fifths the number in which they contributed significantly to fatalities.[4] Of these illnesses, emphysema now registers a death rate eight times higher than in 1951. Between nine and nineteen per cent of all workers granted Social Security System disability benefits for the first time in 1960 had a primary diagnosis of respiratory disease, of which emphysema and tuberculosis were the most frequent.[5] These disorders accounted for 17.5 per cent of all disabilities recorded in New Jersey, representing 1,012 individuals during the same calendar year.[5] While many disabled persons may have their benefits terminated because their conditions have improved, or because they have recovered sufficiently to return to substantial productive employment, only 3 per cent of respiratory disability beneficiaries (excluding those with tuberculosis) enjoy such success.[6] For such individuals, life expectancy is dismal. Analyses show that the ratio of observed to predicted deaths is four and a half to one five years after the onset of significant airway obstruction.[7] Early diagnosis, enlightened management, and critical appraisal of the natural history of these diseases require precision in estimating the presence and degree of pulmonary illness. Pulmonary disability decisions are virtually stereograms, unifying diagnosis, impairment, management and response to treatment into a picture where the perspective of depth comes from the passage of time.

Roemmich[8] has emphasized the tripartite nature of the Disability Insurance Program: (1) submission of medical evidence on behalf of the patient; (2) disability determination examinations by physicians on state agency evaluation teams and (3) medical development and evaluation principles evolved by Social Security Administration physicians. Three questions recur regularly in each of these areas: (1) Is there pulmonary disease? (2) Is there pulmonary insufficiency (i.e., impaired function)? (3) Is there pulmonary disability? The first two of these require *medical*

* Chairman's remarks, "Pulmonary Disabilities," Seminar on Disability Decision, New Jersey Rehabilitation Commission, New Brunswick, November 29, 1967.

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answers based upon objective studies and measurable lung functions, while the third is an *administrative* decision (Table I).

TABLE 1

Three Critical Questions in Pulmonary Disability Evaluation Examinations

1. Is There Pulmonary Disease?
   A Medical Decision — based on objective studies

2. Is There Pulmonary Insufficiency (Impairment)?
   A Medical Decision based upon a reduction in measurable function.

3. Is There Pulmonary Disability?
   An Administrative Decision: A mosaic comprising:

   a. Impairment in the light of occupational exertional demands.
   b. Attitude of the personal physician } Intensity
   c. Motivation of the patient } → of
   d. Education of the patient } Therapy
   e. Ability to avoid pneumotoxins (infection, vapors, etc.)
   f. Personnel policies of employers
   g. Industrial health and disability insurance regulations
   h. Social Factors.

Detection of disease and impaired function are nowhere as unsatisfactory as in bronchopulmonary ailments. Serious limitations in the ability of physicians to recognize emphysema on physical[9] or radiologic[10] grounds have been demonstrated repeatedly. Elsewhere[11] I have summarized the pitfalls in ventilation estimates: limitations in the apparatus and technics; differences in patient motivation, understanding and coordination; fluctuations in the physiologic handicap of the subjects; and disagreement concerning the appropriateness and sensitivity of the various ventilatory tests as indices of impairment and responsiveness to therapy.[11] Others[12] have warned that "the state of the art and the nature of the statistical delineation of normal is such that in the asymptomatic individual any categorization on the basis of the spirogram alone is hazardous and unwarranted." Simplified technics and apparatus developed in the last two decades have made clinical lung tests a reality for daily practice.[13] Yet recent analysis suggests that a serious deficiency exists in the utilization of these methods by the physician in community practice whose primary interests are not tangential to observations in this area.[14]

We are convinced that a few simple procedures, done routinely and systematically, will be useful in this context. A standard checklist and questionnaire modeled on that used by the British Medical Research Council's Committee on Research into Chronic Bronchitis,[15] or distributed by local voluntary health agencies,[16] would record essential data systematically so that the same subjects are likely to be placed into the same grade of severity by different examiners. I have suggested that routine use of Fletcher's criteria for categorizing dyspnea offers a reasonably good insight into the adequacy of ventilation from the details of the history alone,[17] and that simple "match" or DeBono whistle testing[18] improves the accuracy of this estimate.[19] Our experience (Table II) is in agreement with that of Silver,[20] who studied a similar group of disability applicants, in emphasizing the close correlation between the patient's estimate of the circumstances of occurrence of his breathlessness and certain simple lung test indices, although there has been an authoritative dissenting opinion.[21]

The thorny quesetion of which pulmonary function tests are best indices of impairment has yet to be resolved. We find that relatively few numerical measures are necessary for referral and consultative appraisal of breathing handicaps. The maximal voluntary ventilation suffers from the inaccuracies imposed by the need for optimal comprehension, coordination and cooperation, and the hazards of precipitating an asthmatic paroxysm in the interval phase of that disease. The forced expiratory volume for the first 1.0 second ($FEV_{1.0}$) is less dependent upon the former factors and calculation of the "Indirect Maximal Voluntary Ventilation" as suggested by Kennedy[22] ($FEV_{1.0}$ in liters x 40) provides a good approximation of this index. The maximal expiratory flow rate (MEFR) would be a similar objective determination of excellent fidelity.[23] If one adds to these two measurements, the ratio of residual volume to total lung capacity (RV/TLC) as an estimate of over-inflation of the lung, pulmonary function abnormalities will be defined more closely. More recent methods incorporating the three variables of oxygen consumption, maximal voluntary ventilation and exercise may

TABLE II

Ventilation Values for 100 Patients with Bronchopulmonary Diseases Classified According to Gradation of Dyspnea (Fletcher) and Disability Index (Wilson)

Classification	No. of Pts.	Sex M	Sex F	Average Age (Yrs.)	FVC* (in cc's)	$FEV_{1.0}$* in cc's	$FEV_{1.0}$* as % of FVC	MVV* (in l/min)	Snider Match Test** +	Snider Match Test** −
GRADE I										
Dyspnea	23	16	7	40.0	3344.0	2503.2	75.4	89.1	0	23
Disability	8	7	1	38.8	4236.5	3387.5	79.5	127.9	0	8
GRADE II										
Dyspnea	17	11	6	47.7	3011.2	1982.0	66.5	69.5	0	17
Disability	20	17	3	38.0	3194.5	2363.2	76.3	89.1	1	19
GRADE III										
Dyspnea	22	14	8	50.2	2576.5	1619.0	63.5	57.5	2	20
Disability	32	22	10	51.7	2679.9	1812.1	68.9	66.4	7	25
GRADE IV										
Dyspnea	24	21	3	57.6	2191.3	1322.2	57.6	54.3	18	6
Disability	35	20	15	56.5	1955.1	1062.6	54.4	40.5	20	15
GRADE V										
Dyspnea	14	8	6	57.6	1715.7	1038.0	57.0	42.3	12	2
Disability	5	4	1	64.0	1892.2	723.6	39.4	22.3	4	0

*FVC represents forced vital capacity; $FEV_{1.0}$ represents the forced expiratory volume for the first one second; and MVV represents maximal voluntary ventilation.

**A positive test indicates that the patient was unable to extinguish the flare; a negative test indicates the patient was able to extinguish the flare.

provide a better evaluation of the physical working capacity of applicants with bronchopulmonary conditions.[24,25]

All three obstructive ventilatory disorders exhibit a substantial, potentially reversible, physiologic component; the reversibility of any applicant's disease, even when there are severe blood gas abnormalities, cannot be gauged before a trial of therapy.[26] The therapeutic brief prepared by the treating physician is critical in assessing the extent and permanence of the handicaps demonstrated. During the consultative session, the lung tests chosen are of little value unless the indices are repeated after the use of bronchodilator drugs, preferably in aerosol form. We may conclude, with some confidence, that the disorder demonstrated by the pre-treatment studies is at least partly reversible, physiologically, if at least two of the control test values rise 15 to 20 per cent or more after the dilating mist.[11,23,27] It has been striking in disability consultation that, although the great majority of those examined improved significantly in test scores following exposure to dilator inhalants,[20] most had received little or no therapy prior to their certification as disabled.[28] Clearly, manifold and complex patient and physician factors responsible for suboptimal management deserve exploration.

Recently we have incorporated measurements of airway resistance, made with a whole body, volume-displacement plethysmograph, part of routine office disability studies.[29] This method may disclose expiratory airflow disorders when standard spirometry is uninformative, and resistance changes often mirror the real clinical status of many patients better than our conventional indices. The method is less fatiguing than forced ventilation tests, and allows the most accurate measurement of thoracic gas volumes and calculation of the RV/TLC ratios. Furthermore, when airway resistance (Ra) is related to the specific volume of thoracic gas at which it is determined (TGV) the product of these two values can smooth out the spontaneous fluctuations in lung function characteristic of obstructive lung disease, and is the most sensitive estimate of the ability of the airways to respond to bronchodilator therapy.[30] Although the equipment is costly, (usually restricting its use in this country to academic and research settings), our experience has been that maintenance costs are negligible for doing a great many examinations of high fidelity and re-

TABLE III

Synthesis of Pulmonary Disability Ranking Schemes

Category	Fletcher[31]	Silver[20]	Schneider & Anderson[9]	Am. Coll. Chest Physicians[36]	Wilson et al[34]	A. M. A.[33]	Gilbert et al[32]	M. C. S. Kennedy[35]
I	A-I	A-1	D (80–120%)	D (80% or >)	I A-I-1 B-2 C-1 or 2 E-1 F-1	I (0% Imp.) A-I-1 B-1 C-1 D (85% or >)	I A-1	I D (80% or >)
II	A-II	A-2 ("Mild")	D (60–79%) ("Mild")	D (65–79%) ("Mild")	II A-II-2 B-2 C-2 E-2 F-1	II (20% Imp.) A-II-2 B-1 C-1 or -2 D (70–85%)	II A-2	II D (<80%-attacks) (>80%-intervals)
III	A-III	A-3 ("Moderate")	D (40–59%) ("Moderate")	D (50–64%) ("Moderate")	III A-III-3 B-2 C-2 E-3 F-2	III (40–50% Imp.) A-III & IV, -2 B-2 C-(?1)-2 D (55–70%) G-1	III A-3	III D (always <80%) (D-1)
IV	A-IV			D (35–49%) ("Severe")	IV A-IV-4 B-2 C-2 E-4 F-2-3			IV D (always<80%) (D-2)
V	A-V	A-4 ("Severe")	D (<40%) ("Severe")	D (<35%) ("Very Severe")	V A-V-4 B-2 C-2 E-3	IV (69–90% Imp.) A-V-3, 4 B-2 C-2 D (<55%) G-2	IV A-4	V D (always<80%) (D-3)

1 — 2 flights of steps
2 — 1 flight of steps
3 — ½ flight of steps
4 — 0 steps

A — DYSPNEA
- I — Performance on walking and climbing hills and stairs as good as that of other persons of similar age and build
- II — Normal performance on walking, but inability to keep up with others on hills and stairs
- III — Ability to walk a mile or more at own speed, but inability to keep up with others
- IV — Inability to walk more than 100 yards without a rest
- V — Breathlessness on talking or undressing and inability to leave the house

B-PHYSICAL SX
- B-1 Absent
- B-2 Present

C-XRAY OF THE CHEST
- C-1 Normal
- C-2 Abnormal

D-LUNG FUNCTION
- D (% Of Predicted)
- D-1 To normal with Rx
- D-2 Improved but not to normal with Rx
- D-3 No improvement with therapy.

E-THERAPY REQUIRED
- E-1 None
- E-2 Needed Intermittently
- E-3 Needed at all times
- E-4 Intensive at all times

F-CYANOSIS
- F-1 None at rest or on exercise
- F-2 None at rest; on exercise only
- F-3 At rest and on exercise

G-ARTERIAL O_2 SATURATION
- G-1 > 88%
- G-2 < 88%

producibility in untrained subjects. These features are responsible for inclusion of airway resistance measurements in routine evaluation of lung impairment in the social security deliberations of several European nations.

Referring and consulting physicians can aid disability review teams by organizing their findings into a consistent and systematic classification embodying these salient estimates from history, physical examination, x-ray, and laboratory studies and allowing them to fix *medical* impairment of the applicant on a semi-quantitative basis. Table III organizes the common features of eight recent attempts at grading lung impairment[9,20,31-36] into five approximate major categories. This numerical estimate can then be posed against the backdrop of the multitudinous factors — occupational exertional demands, attitudes and motivation of patient and physician, personnel policies of industry and their health and disability regulations, and other socio-economic elements — that comprise the mosaic of the disability decision.[37-40]

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230 West Jersey Street

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Meetings

March 17, 1968

A regular meeting of the Board of Trustees was held at Notre Dame High School, Trenton, on Sunday, March 17, 1968. For your further information, detailed minutes are on file with the Secretary of your county society. A summary of the significant actions follows:

Woodrow Wilson School (Princeton University) . . . Received the report of President Collins which included the following:

The Woodrow Wilson School of Princeton University is conducting round-table discussions regarding the growing issue of medical care in New Jersey. The meetings will be closed and unrecorded — except that the round-table's final conclusions will be presented to the Governor if the group so elects. Dr. Collins has been invited to participate in this series. He so reported for the information of the Board.

New Jersey Hospital Association . . . Directed that a letter of congratulations be sent to the Executive Director of NJHA on the occasion of the celebration of its golden anniversary in conjunction with its annual meeting on April 25th.

Minimum Fees For Office Visits . . . Directed that Middlesex County Medical Society be officially informed that no minimum fee has ever been recognized in New Jersey for an office visit, or for any other service.

Methadone Maintenance Program . . . Approved the following recommendation from the Council on Mental Health (Special Committee on Drug Addiction):

That MSNJ approve in principle the proposed research project for a Methadone Maintenance Program to be conducted by the Director of the New Jersey State Drug Substance Dependency Section.

Mental Retardation — Liaison with Interested Agencies . . . Approved the following recommendation from the Council on Mental Health (Special Committee on Mental Retardation):

That Dr. James Butler, Medical Consultant to the Department of Institutions and Agencies, be appointed as a Consultant to the Special Committee on Mental Retardation, in keeping with the decision to focus on establishing close working relationship with governmental and private agencies.

Physicians' Services Under Medicare (Part B) Approved the following recommendations from the Council on Medical Services, subject to the concurrence of the 1968 House of Delegates:

(1) That a committee be set up at State level to screen cases which, the fiscal intermediary feels, *may* involve a question of medical ethics or professional conduct under Part B of Medicare.

(2) That the screening committee consist of five members, *to be appointed by the Board of Trustees,* one from each of the Judicial Districts of The Medical Society of New Jersey, with a representative from Prudential as a consultant.

Council on Public Relations . . . Approved the following recommendation from the Council:

That component societies be encouraged to review their meeting programs and activities in an attempt to achieve better attendance.

Liability Insurance . . . Unanimously decided that it could not accept the terms under which American Mutual was willing to reinstitute coverage for members of our society. The Board thus accepted as final American Mutual's decision that it "would retire from the current policies at expiration on October 31, 1968." The Board further directed that this information be sent to American Mutual under date of March 18, 1968 *via* registered mail. The following is pertinent to the above action:

As directed by the Board at its preceding meeting, a conference was held on February 28 with representatives of the American Mutual Liability Insurance Company, to discuss the basis for the expressed decision of the company to discontinue coverage of new members as of January 15, 1968 and to terminate total coverage as of November 1, 1968.

As a result of this conference and subsequent correspondence, American Mutual indicated its willingness to resume underwriting professional liability for members of MSNJ, provided their proposed 52.3 per cent rate increase was acceptable to the New Jersey Department of Banking and Insurance and subsequently to MSNJ. In support of its submission to the New Jersey Insurance Department, American Mutual requested a resolution of acceptance and approval from the Board. American Mutual also indicated that it would not re-open new courage until the commissioner had approved the new rate filling.

Conference on Health Education of the Public . . . Authorized the President to attend (with expenses paid) the AMA Conference on Health Education of the Public, to be held in Chicago in April.

AMA Board of Trustees . . . Directed that the name of Joseph P. Donnelly, M.D. of Jersey City be submitted in nomination for membership on the AMA Board of Trustees, to fill the vacancy created by the retirement of Dr. Gerald D. Dorman of New York.

MSP Board of Trustees . . . Approved the following nominations for terms on the Board of Trustees of Medical-Surgical Plan of New Jersey and referred them to the House of Delegates for action:

Three-year term (1968-1971):

Name	*Type of Practice*	*Member of Component Society*
Edwin H. Albano, M.D.	Pathologist	Essex County
James Crowley	Businessman	—
Lloyd M. Felmly	Retired Newspaper Editor	—
Samuel J. Lloyd, M.D.	Surgeon	Mercer County
Theron L. Marsh	Banker	—
Jesse McCall, M.D.	Internist	Sussex County
Rudolph C. Schretzmann, M.D.	Obstetrician	Bergen County
Charles O. Tyler, M.D.	Pediatrician	Camden County
Thomas J. White, M.D.	Internist	Hudson County

Two-year term (1968-1970):

Henry J. Mineur, M.D.	Internist	Union County

One-year term (1968-1969):

Donald T. Akey, M.D.	Surgeon	Middlesex County

AMA Annual Meeting . . . Authorized (subject to confirmation at the reorganization meeting of the Board in May) attendance at the AMA Annual Meeting in San Francisco (with expenses paid) of the President, President-Elect, Executive Director, 7 regular Delegates, and 1 Alternate Delegate (Dr. John J. Bedrick, named by action of Board.)

Join Us On June 12

Four past presidents of the American Psychiatric Association will speak on "Psychiatry in Transition," at a one-day symposium, June 12, sponsored by the Division of Mental Health and Hospitals of our State Department of Institutions and Agencies. Speakers include Daniel Blain, M.D., medical director of the Philadelphia State Hospital and APA president in 1964-65; Howard P. Rome, head of the psychiatry section of the Mayo Clinic, APA's 1966 president; Francis Braceland, M.D., senior consultant at the Institute for Living in Hartford, and APA president in 1957; and Kenneth E. Appel, M.D., professor emeritus at the University of Pennsylvania, and APA president in 1953-54.

Individual observations of past and present trends in the development of psychiatry as a medical specialty; changing social and professional expectations; and evaluation of psychiatry's current status and future orientation will be among the themes to be presented. A panel composed of the three remaining speakers will react to each address. The moderator will be V. Terrell Davis, M.D., our state's director of the Division of Mental Health and Hospitals.

The symposium, to be held at the Cultural Center in Trenton, is in celebration of the 50th anniversary of the Department of Institutions and Agencies. The program was arranged by Paul Haun, M.D., the Division's director of psychiatric education. For more details, write to Dr. Haun at 135 West Hanover Street, Trenton 08625.

Hospitalization For The Mentally Ill In New Jersey

New Jersey has many resources for hospitalization of its mentally ill. These may be in:

A. *In-patient psychiatric facilities in general hospitals:* Usually, there are no formalities for admission except the patient's wish to be treated. There are no formal commitment procedures unless the hospital has requested and been approved for this by the Department of Institutions and Agencies.

B. *Private psychiatric hospitals:* These hospitals are approved to admit patients by means of formal commitment procedures. Check with the hospital prior to referring a patient.

Carrier Clinic—Belle Mead, New Jersey—201-359-3101

Fair Oaks — Summit, New Jersey — 201-277-0143

C. *County psychiatric hospitals:* These hospitals admit patients *via* formal commitment procedures. They provide service to county residents only — defined as those who have lived in that county for five years.

Atlantic County Hospital (Northfield) 609-641-3456

Burlington County Hospital (Evergreen Park) 609-894-2235

Camden County Hospital (Lakeland) 609-227-3000

Cumberland County Hospital — 609-451-2888

Essex County Hospital (Overbrook) 201-239-1900

Hudson County Hospital — 201-863-5100

D. *State psychiatric hospitals:* Each State Hospital serves a specific "catchment area" for committed patients. Voluntary patients may be admitted from outside the catchment area, at the discretion of the Medical Director.

Ancora Psychiatric Hospital — 609-561-1700
Receives patients from: Atlantic County, Burlington County, Camden County, Cape May County, Cumberland County, Gloucester County, and Salem County.

Greystone Park Psychiatric Hospital — 201-538-1800
Receives patients from: Bergen County, Essex County (except Newark, Belleville, and Nutley), Morris County, Passaic County, and Sussex County.

Marlboro Psychiatric Hospital — 201-946-8100
Receives patients from: Middlesex County, Monmouth County, Ocean County, and Union County.

New Jersey Neuro-Psychiatric Institute — 609-466-0400
Receives patients from Somerset County only.

Trenton Psychiatric Hospital — 609-396-8261
Receives patients from: Essex County (only if living in Newark, Belleville, and Nutley) Hudson County, Hunterdon County, Mercer County, and Warren County.

Admission Papers and Commitment Forms

Private psychiatric hospitals print their own commitment and voluntary admission forms. The doctor may get the proper forms from the appropriate hospital.

Each county hospital prepares its own commitment and voluntary forms, which can be obtained from the County Adjuster of that county, or from the hospital concerned.

The five State psychiatric facilities use the same commitment papers. These are supplied to the County Adjusters, from whom the family can get the forms. Voluntary papers are available at the admission offices of each hospital and are completed there by the patient who is seeking admission.

How Patients May Be Admitted

While this information is specific for the five State psychiatric hospitals, it also applies to the private psychiatric hospitals in general. Specific information may vary for the private psychiatric hospital and the physician is advised to contact the individual private psychiatric hospital in advance for specific procedures.

I. *Voluntary Admission:*

Any patient over the age of 18 may seek voluntary admission to a psychiatric hospital. Any minor under the age of 21, may be admitted on a voluntary application of a parent, guardian, grandparent, adult brother or sister. Voluntary papers are made out by the patient, (or by the person applying for him in the case of a minor under 21), at the admission office of the psychiatric hospital. The admitting physician evaluates the applicant's mental competency to seek voluntary admission. The patient must be aware that he can request his release from the hospital and that

he will be discharged within 72 hours of making that request unless the medical staff is of the opinion that he is a danger to himself or others, in which case he would be committed.

II. *Regular (two physicians' certificates) Commitment Procedure:*

This requires an application and two physicians' certificates on a special commitment form.

Application for admission may be made by any of the following:

1. A relative (by blood or marriage).
2. Someone having charge of the person.
3. The Sheriff.
4. The County Prosecutor.
5. The Municipal or County Director of Welfare.
6. The person charged with the care and relief of the poor.
7. Any Chief of Police or Police Captain of any municipality in the State where such patient may be.
8. The Chief Executive Officer of any correctional institution or of any public or private charitable institution or hospital in which the patient may be.
9. The Commissioner of Institutions and Agencies.

III. *Physicians' Certificates: (two required):*

The physician must:

1. Be licensed to practice medicine in some State in the U.S.A.
2. Not be related to the patient. (by blood or marriage).
3. Not be the Director, Chief Executive Officer or Proprietor of the hospital to which the patient is being committed.
4. Have examined the patient within 10 days of the patient being presented for admission.
5. Complete all sections of the certificate (i.e.: provide the requested information).

If the mental condition of the patient permits, a judge's order is obtained (known as the "temporary order") and the patient is admitted as a "Class-B Commitment."

The physician's certificate is only valid for 10 days. If a patient is brought to the admission office 11 days after examination (for example), he cannot be legally admitted on that examination certificate. That a temporary order may have been obtained in no way reactivates a commitment examination that is more than 10 days old.

If the mental condition of the patient is such that he must be *immediately* admitted, prior to a judge issuing a temporary order, then the patient can be admitted on the basis of the application and the two valid physicians' certificates. This is known as a "Class-C Commitment" and the hospital obtains the temporary order following the patient's admission.

The "temporary order" is valid for a limited period of time. During this period, the County Adjuster receives a copy of the commitment papers and arranges a judicial hearing at which time it will be determined (a) is there need for the patient to remain in the hospital past the temporary period? and (b) who will pay for the patient's maintenance in the hospital?

If need for hospitalization is not urgent, and it is possible to hold the judicial hearing *prior* to the patient's admission to the hospital, then the patient is admitted on this "final order." This is a "Class-A Commitment."

When the County Adjuster has arranged for the judicial hearing, the patient is served notice of this hearing and is advised of his right to be present at the hearing, or to be represented by council. He is offered assistance in this.

IV. *7-Day Commitment (certificate for temporary admission: the one-doctor form):*

This certificate permits the hospitalization of the patient for up to 7 "regular working days" (i.e.: excluding weekends and holidays). There is no application and the admission is only on the basis of the physician's examination. All the rules concerning the physician's certificate for the regular commitment hold here. There is no further judicial review of the admission. At the end of the 7 days, the patient must either be discharged or be picked up on some other type of admission.

The Medical Director of the hospital has the right to decide whether patients will be 'ad-

mitted to his hospital on 7-day commitment papers.

The Essex County Overbrook Hospital does *not* accept any patient on the red form — the "7 day-one-doctor" commitment. Two medical certificates are needed there and for any other hospital where the Medical Director decides against admitting a patient on a "one-doctor" form.

While The Patient Is Hospitalized

The mental patient's "Bill of Rights:"

1. Right to humane care and treatment and to education.
2. Right to participate in treatment plan.
3. Limitation of mechanical restraints.
4. Right to be protected in an emergency.
5. Exercise of civil and religious rights; right to communicate and have visitors.
6. Right to *habeas corpus.*
7. Right to privacy.

Release From Hospitalization

Discharge: A patient may be discharged from a mental hospital in accordance with the rules of the hospital. *Discharge* is the termination of legal jurisdiction of the professional staff of the hospital over the patient. There is nothing to prevent the professional staff from providing or offering further professional services on an out-patient basis, or assisting the patient in obtaining these from some other source.

Release on Family Care: (applies only to State psychiatric hospitals) This is a program conducted under the regulations of the State Board of Control for the placement with suitable private families or in Boarding Homes holding a certificate of approval (in accordance with State law) of individuals eligible for care in mental hospitals or for functional services for the retarded, who have no need for professional nursing services, who have no suitable homes of their own, and who have no relatives able to provide minimum shelter and care. Patients are placed in the Family Care program pursuant to Family Care regulations and continue to be patients of the mental-hospital until formally discharged.

Questions And Answers

Question: Does the physician have to be in practice for five years in order to write a Commitment Certificate?

Answer: No — The only requirements are:
a. Full medical licensure in some State.
b. Not related to the patient by blood or marriage.
c. Not the Chief Executive Officer, Medical Director, or proprietor of hospital to which the patient is to sent.

Question: Does the committing physician have to be a psychiatrist?

Answer: No — While the psychiatrist is presumably more expert in the field of mental and emotional diseases, all the law requires is that the physician be of reputable character and possess a full license to practice medicine in any State in the Union.

Question: Will I have to go to Court if I write a commitment certificate?

Answer: You may have to, if the patient contests his commitment. This judicial hearing is to protect the patient's civil liberties. The committing physician's presence in Court is to clarify to the Court the need for hospitalization of the patient.

Question: Does the patient have to be a resident of New Jersey in order to be admitted to a State psychiatric hospital?

Answer: No. Non-residents are admitted to State Hospitals (not to county hospitals) on the same basis as our residents. Following his admission, the hospital staff will evaluate all factors and decide on whether the patient should be retained in a New Jersey hospital, or whether he should be returned to his home State. The available resources for that particular patient's rehabilitation is the major factor in arriving at this decision.

Question: Who pays for the patient's maintenance at the State hospital?

Answer: The patient, or estate, or those chargeable for his welfare. Maintenance payments are one of the matters decided on at the judicial hearing. If the patient is indigent and is a county resident, the county will pay one-half the maintenance cost and the State the other half. If patient is indigent and is not a county resident, the State pays the entire amount.

Question: Is a patient committed to a mental hospital considered legally incompetent?

Answer: No. The question of competency to manage ones affairs is an entirely separate issue.

Sample

Sample

STATE OF NEW JERSEY

CERTIFICATE OF PHYSICIAN FOR TEMPORARY ADMISSION TO A STATE, COUNTY OR MUNICIPAL HOSPITAL (under Title 30:4-46.1)

To the Chief Executive Officer of ..... Hospital

I, ... M.D. of .....
(STREET AND TOWN OR CITY)

in the County of ..... and State of .....

do hereby certify that I am duly licensed in ....., ...
(STATE) (MEDICAL LICENSE NO.)

On the ..... day of ....., nineteen hundred ....., I made a personal examination of ..... who resides at ..... in .....
(STREET) (CITY OR TOWN)

and the County of ..... and the State of .....

and found said person to be suffering from a mental or nervous illness or from a psychosis caused by drugs or alcohol which renders said patient incapable of executing a voluntary application for admission.

I further certify that the condition which I have observed and which is described herein is such as to require his immediate hospitalization as provided for in Title 30:4-46.1 (N.J.S.A.) for a period of not exceeding seven days, excluding Saturdays, Sundays and holidays, so that said patient may undergo a period of observation to determine what further treatment shall be necessary for his health and safety and welfare and that of others in the community. I am not the director, Chief Executive Officer or proprietor of said hospital nor am I a relative, either by blood or marriage, of the patient.

My staff appointment to the receiving hospital is .....

The following is a thorough description of the patient: .....
(NAME)

of ..... : Social Security No. .....
(ADDRESS) (TOWN)

Is patient receiving any benefits ..... If so, specify (Pensions, VA, Social Security) .....
(YES OR NO)

Hospitalization Insurance ..... Company (Blue Cross, etc.) .....

and number ..... Occupation .....

Military Service ..... Dates .....

Type of discharge ..... VA Claim Number .....

Date of birth .....; height .....; weight .....;

color .....; sex .....; marital status .....;

color of eyes .....; color of hair .....;

Name, relation, and address of next of kin .....

The following is a report of my medical findings:

1. History of Previous Illness (Including mental illness) and/or previous hospitalizations .....

2. History of onset of present illness including predisposing factors; .....

3. Mental Status (Describe in detail the patient's behavior, appearance and manner. State what the patient said.) .....

4. Additional facts and circumstances (including facts communicated by others) upon which my judgement is based .....

5. If applicable, carefully delineate and describe tendencies for destructive, homicidal or suicidal behavior; depression, violence or excitement .....

6. Medication (Type and Dosage) .....

7. History of Use of Alcohol .....

8. Describe the patient's physical findings; physical status; vital signs; blood pressure; laboratory data; please forward abstract copies of medical reports .....

9. Specify the exact condition observed .....

..... M.D.

Sample

Sample

STATE OF NEW JERSEY

Certificate For Hospitalization (under Title 30: N.J.S.A.)

COUNTY OF .....

Request For Admission of .....

To: ..... Hospital

The undersigned ..... of .....
(NAME OF PERSON MAKING APPLICATION) (STREET AND TOWN)

in the County of ..... and State of .....

hereby makes application for admission to the .....

Hospital and hospitalization therein, of .....
(PRINT)

of the County of ..... and State of .....

The said ..... was born on .....
(DATE OF BIRTH)

at ....., in the County of .....,
(CITY OR TOWN)

and State of ....., and County of .....

and is by occupation a .....
(PROFESSION, TRADE OR CALLING)

Marital Status ..... Citizen .....

Education: (highest grade completed) .....

Name of father ..... (living, deceased); birthplace .....

Maiden name of mother ..... (living, deceased); birthplace .....

The place or places in which the said patient resided during the ten years immediately preceding the date of the application are:

....
(STREET, TOWN) (FROM DATE) (TO DATE)

....
(STREET, TOWN) (FROM DATE) (TO DATE)

Names, relationship, and addresses of the next of kin of said patient are:

(NAME) (RELATION) (STREET) (TOWN) (STATE) (ZIP CODE) (TEL. NO.)

.....

.....

.....

Social Security No. ..... Is patient receiving any benefits? .....
(YES OR NO)

If so, specify (Pensions, VA, Social Security) .....

Hospitalization Insurance ..... Company (Blue Cross, etc.) .....

..... and Number .....

Military service ..... Dates .....

Type of Discharge ..... VA Claim Number .....

Date ....., 19 .

Name of person making application .....
(PRINT)

Relationship or Position .....
(PRINT)

Street and Number .....
(PRINT)

Town or City ..... Zip Code .....
(PRINT)

County of ..... State of .....
(PRINT) (PRINT)

Telephone Number (include area code) .....

.....
(SIGNATURE OF APPLICANT)

Sample

Sample

Certificate of Mental Illness

I, ..., M.D. of .....
(PRINT) (STREET AND NUMBER)

....., ..., ...
(CITY OR TOWN) (COUNTY) (STATE)

..... of ..... do hereby certify that I personally
(MEDICAL LICENSE NO.) (STATE)

examined ..... on the .....

day of ....., 19 . I am not the director, chief executive officer or proprietor of any
(MONTH)

institution for the care and treatment of the mentally ill to which application for admission is being prepared; nor am I a relative, either by blood or marriage of the patient. My staff appointment to the receiving hospital is .....

The following is a description of the patient: ..... ;
(NAME)

.....; date of birth: ..... ;
(ADDRESS)

height .....; weight .....; color .....; sex ..... ;

marital status ..... ; color of eyes .....; color of hair .....

The following is a report of my medical findings:

1. History of Relevant Previous Illnesses (include mental illness) and/or previous hospitalizations:

   .....

   .....

2. History of onset of present illness including predisposing factors:

   .....

   .....

3. Mental Status (Describe in detail the patient's behavior, appearance and manner. State what the patient said.)

   .....

   .....

   .....

4. Additional facts and circumstances (including facts communicated by others) upon which my judgment is based: .....

   .....

5. If applicable, carefully delineate and describe any destructive, homicidal or suicidal behavior; depression, violence or excitement.

   .....

   .....

6. Medications (give all known information about medically prescribed or self-administered use of medications or toxic substances.) .....

   .....

7. History of Use of Alcohol .....

8. Describe the patient's physical findings; physical status: vital signs; blood pressure; laboratory data; please forward abstract copies of medical reports.

   .....

   .....

On the basis of the foregoing, I believe that the condition of this person is such as to require evaluation, care and treatment in a mental hospital.

..... M.D.

Sample

Sample

Order Instituting Inquiry and Hospitalizing Patient For Temporary Period

(To be used in "Class B" cases only.)

State of New Jersey, County of .....

Before .....
(JUDICIAL OFFICER)

Application, in writing, being made by .....

requesting the admission and hospitalization in the .....

of .....

hereinafter called the "patient," as a mentally ill person, to which attached certificates of .....

and ......, practicing physicians of the State of ..... and the State

of ...., setting forth, that said patient, in their judgment, is mentally ill, and that

..... condition is such that ..... should be hospitalized, and said application and the said

certificates in the form required by law, being presented to me, it is, on this ..... day

of ....., 19.....,

Ordered, that inquiry be instituted and proofs taken as to the mental illness, legal settlement and ability to pay of said patient before ....., a judicial officer of the County of ..... at a time and place to be designated, by .....; and it is further
(NOT MORE THAN 20 DAYS FROM ADMISSION OF PATIENT)

Ordered, that the patient be admitted to and hospitalized in the ..... Hospital, pending said judicial hearing, for a period not exceeding twenty days from the date hereof, or until further ordered in this proceeding, as provided by statute, unless patient is otherwise released by due process of the law.

....., Judge

Outpatient Services Under Medicare

Hospital outpatient services, whether for diagnosis or for treatment, are covered now only by medical insurance (part B) not by hospital insurance under Part A. This means that all hospital outpatient benefits will be subject to a $50 deductible and a 20 per cent coinsurance feature.

Under the old law, benefits were paid on the basis of a "diagnostic study." This was a 20-day period during which a patient received diagnostic services from the same hospital. For each such 20-day period, the patient was required to pay the first $20, and his hospital insurance paid 80 per cent of the remaining costs. The $20 deductible he paid under the hospital insurance plan counted toward the $50 deductible under the medical insurance plan.

The new law relieves administrative complexities in the old law that were created by the existence of two deductibles, by the need to distinguish diagnostic services from treatment, and by separate procedures for the handling of those services rendered by a physician and those not rendered by a physician.

Hospitals will be permitted, under the new law, to collect up to $50 for outpatient hospital services from the medicare beneficiary. These amounts, of course, will be counted as expenses reimbursable to the beneficiary under the medical insurance plan. This provision of the 1967 amendments will bring the requirements of the medicare program more closely in line with the usual billing practices of hospitals.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of March:

	March 1968	*March 1967*
Aseptic Meningitis	5	7
Primary Encephalitis	0	2
Post-Infectious Encephalitis	0	1
Hepatitis, Total	180	160
Infectious	162	131
Serum	18	29
Malaria (Servicemen)	17	10
Meningococcal Meningitis	32	12
Mumps	760	N. R.*
German Measles	380	N. R.*
Measles	97	92
Salmonella	42	17
Shigella	7	10

Rocky Mountain Spotted Fever

Possibly because of its name, Rocky Mountain Spotted Fever (R.M.S.F.) is seldom considered the cause of a febrile illness with rash in New Jersey. Actually, the incidence of this infection in the Middle Atlantic seaboard states is believed to be only second to that in the Rocky Mountain area. During the four year period 1964 to 1967, there were 53 serologically confirmed cases of R.M.S.F. in New Jersey. Cases occurred from April to September with a peak during late spring and early summer. Cases have occurred in 14 of the 21 counties in New Jersey with the majority of cases coming from the southern and central part of the state.

The ratio of males to females in these cases was 2:1 and more than fifty per cent of the cases were under 15 years of age. Thus the young boy who is apt to play in the woods or with animals is most likely to be bitten by a tick. The vector tick in New Jersey is felt to be Dermacentor variabilis or the "Brown Dog Tick."

A definitive diagnosis of R.M.S.F. can be confirmed by a specific complement-fixation test. Complement-fixing antibodies usually appear during the second or third week in patients who receive no specific therapy, but may be delayed or absent in those treated early in the disease. The Weil-Felix agglutination reaction may also be used as a presumptive diagnostic test for R.M.S.F. infection.

Large doses of tetracyclines are effective and should be used early in the course of the disease. Because the clinical diagnosis of this disease is rarely suspected and because of the wide usage of antibiotics, probably many cases of R.M.S.F. go undiagnosed in New Jersey. The Communicable Disease Control Program would appreciate hearing of any suspect cases of R.M.S.F. and the State Laboratory is equipped to do the complement fixation and Weil-Felix test.

Erythema Infectiosum ("Fifth Disease")

Since January a rash illness which is compatible with Erythema Infectiosum or "fifth disease" has occurred throughout the state. Clusters of cases have been reported in Morris, Middlesex, Burlington, and Union Counties. Since many physicians are unfamiliar with this disease, and since the diagnosis may be difficult to make unless there is an epidemic, we felt a brief description would be of value.

The illness usually involves children from 3 to 12 but all age groups may be involved. The first stage of the rash begins with fiery-red cheeks with some circumoral pallor. Some describe this as a "slapped-cheek" appearance. Usually there is no prodrome and rarely are there constitutional symptoms. With the onset of the second stage occurring one to two days later a lacelike rash with some maculation at the periphery appears mainly on the arms and legs and may spread to the neck, chest, and buttocks. A third stage, lasting one to three weeks is characterized by evanescence and recrudescence of the rash, as related to sunlight or trauma. The most characteristic diagnostic feature is an outbreak of an illness with an erythematous rash with almost no other signs or symptoms. The differential diagnosis includes rubeola, roseola, rubella, scarlet fever, drug reactions, and erythema multiforme. The etiologic agents for this disease have not been identified.

*N. R. Reporting only since October, 1967.

Meningococcal Meningitis

All cultures of N. meningitis which are submitted to the State Bacteriology Laboratory are submitted to two centers for Sulfadiazine resistance testing, since some reports estimate that 30 per cent of N. meningitis are resistant to sulfa. Knowledge of areas in New Jersey were resistance has been reported is important for the determination of therapy. During 1967-1968, N. meningitis resistant to sulfadiazine has been reported from Essex, Hudson, Ocean, and Union Counties.

Your "Hot News" Service

It used to be that a layman could come into your office swinging a copy of a popular magazine and demanding that you prescribe the wonder drug or the new treatment technic dramatically detailed in the magazine. If you said (truthfully) that nothing about that had appeared yet in the scientific press, your patient would think you were a careless reader — or that medical journals were slow-pokes. Furthermore, advances in medical science have become so vast that even if a physician abandoned his practice and spent all his time reading medical literature, it would be impossible for him to cover it all. That's why the service performed by the AMA's Medical News Department fulfills such a vital role in medical communications today. Its product, appearing each week in the "Medical News" section of JAMA, is 14 pages of concise, up-to-the-minute, authoritative news of research and medical meetings.

Because most practicing physicians do not have time to attend more than four or five medical meetings a year, the Medical News staff, comprised of seven science writers and editors, goes where you probably can't. This team travels throughout the United States, annually covering 150 to 160 scientific meetings considered especially significant. Some 85 per cent of these have a direct relationship to medicine. The remainder deal with physics, biochemistry, and other closely related scientific disciplines.

An increasing amount of research is being done in laboratories and clinics financed by the federal government. More and more decisions being made in Washington have a direct and profound effect on medical research. One member of the staff, therefore, is assigned to the Washington Office.

From its onetime limited role of merely reporting professional items of interest, the Medical News Department has grown steadily in recent years to meet its obligation of keeping the practicing physician informed on what is taking place on the medical scene. Staff members file their stories by teletype or telegraph direct from meeting sites. This permits prompt review and appropriate follow-up. The result is that stories can be published within three weeks, quite rapid for a medical publication.

Unlike the lay press, which limits its news of medicine to topics which are most interesting to the public, the Medical News staff is concerned only with presenting topics which are most interesting to physicians. "The spectacular," points out John Connors, director of the Medical News Department, "is quite different from the significant. In our role we must talk to the physician in his language and provide him with the information he needs to make a proper judgment on scientific developments." A lay press article, for example, may report that a new drug administered to a test group of 50 persons has purportedly resulted in improvement of 48 of the patients. This report will be meaningless to the scientifically oriented physician. He will want to know how many controls were used in the test, how the drug was used in the past, what research technics were used, what the exact dosage and other measurements were, and other pertinent information.

Immediately after seeing popularized reports in the lay press, patients are likely to approach their physician about these "new discoveries" that appear, to them, to have a bearing on their ailment. The Medical News section of JAMA now brings information on these subjects to your attention as soon as it becomes available. Benefiting from its con-

tacts, throughout the nation, the Medical News staff is keenly aware of what is occurring in all medical areas of interest. Consequently, many of its articles are "firsts." About 25 per cent of its coverage deals with interviews of researchers in their laboratories when they are about ready to report of their work.

National Medical Standards

Dr. Dwight L. Wilbur, president-elect of the American Medical Association, warned that *physicians will resist any effort to establish national medical standards* under the Regional Medical Programs. But, he added, the medical profession would cooperate enthusiastically if the programs are carried out on a voluntary cooperative basis.

Unlike many other countries, explained Dr. Wilbur, our nation has reached its preeminence in many areas because of its unique combination of multiple independent focal points of activity cooperating on a voluntary basis to achieve a commonly desired goal. If Regional Medical Programs become an instrument for the establishment of national standards with the coercive compliance compelled by such standards, it will arouse nationwide resistance from physicians, institutions, and allied health professionals. What can be gained by cooperation and meaningful participation will surely be lost if the use of coercive power, which for the moment lies dormant in Public Law 89-239, becomes its dominant characteristic.

You And Your Elderly Patient

"The Practitioner and The Elderly" is the first in a series of four publications to be released under the general title "Working with Older People: A Guide to Practice," and has already been issued by the Public Health Service, United States Department of Health, Education, and Welfare.

Describing aging and the world of health care, "The Practitioner and The Elderly" is aimed at helping you understand the elderly person and the accompanying physical, mental, social, and emotional changes that come with age. The publication also provides background on health maintenance in care of the elderly and guidelines for the planning of community health services for the elderly.

The other three volumes in the series will be published during 1968 or 1969. The second volume will focus on the emotional, biologic, psychologic, and sociologic aspects of aging. The third volume will contain syllabi dealing with specific health problems that concern the aging, such as cardiovascular diseases, nutritional deficiencies, and rehabilitation needs. The final volume will deal with social welfare as it relates to the health status of the elderly.

The series is directed at all health professionals who serve the aged. Greatest emphasis, however, is placed on the orientation of the physician, since it is he who occupies the controlling role in provision of health services and in the formation of attitudes toward health by other health-related professionals and by the aged themselves. Other practitioners who could benefit from this publication include dentists, nurses, social workers, therapists, nutritionists, podiatrists, and administrators and staff members of long-term care institutions.

An important application of the comprehensive and integrated body of knowledge in applied gerontology, contained in the four volumes, will be its use as resource material in the development of curricula for short-term institutes and workshops for health professionals.

Single copies of "The Practitioner and The Elderly" (PHS Publication No. 1459, Vol. 1) are available without charge from the Division of Chronic Diseases, Public Health Service, 4040 North Fairfax Drive, Arlington, Virginia 22203. The publication may be bought in quantity from the Superintendent of Docu-

ments, Government Printing Office, Washington, D. C. 20402, at 40 cents a copy or $30 per 100 copies.

"As I Say—Not As I Do"

More than half of the cardiologists participating in Marion Laboratories' monthly national physicians' poll would *not* consent to heart transplant surgery if *they* had advanced heart disease with a poor prognosis. Only 27 per cent of the heart specialists in the Playback doctor panel stated that they *would* consent to heart transplantation, with another 20 per cent undecided.

The negative response of non-cardiologists was similar, but to a lesser extent. Forty-two per cent of these doctors indicated that they would not consent to transplantation, while 36 per cent said yes with 23 per cent undecided.

The Playback panel consists of 9500 doctors nation-wide. The responses tabulated in this report include 218 cardiologists (from 800 polled) and 2103 other physicians (from 8700 polled).

Each month Marion Laboratories provides members of the physician opinion panel with a summary of the previous month's major world news events on a specially prepared long play record produced by the National Broadcasting Company. Accompanying the record is the opinion poll questionnaire, which is completed by the doctor and then returned to Marion to be tabulated by computer. Thus, heart transplantation was discussed in detail in the December 1967 news record, which was received by physicians late in January 1968. The poll asked those physicians who answered "no" to the question on consent to transplant for the reasons they answered in the negative.

"Rejection phenomenon" was the reason listed most often by respondents (44 per cent of the cardiologists, 34 per cent of the non-heart specialists). Only 15 per cent of the cardiologists and 20 per cent of the other physician respondents said that the "surgical risk" was their reason for not being willing to consent to heart transplantation. "Moral reasons" were indicated by 4 per cent of the cardiologists and by 13 per cent of the other doctors.

"There is a time to live and a time to die," said one cardiologist, who further explained that he felt that when his life was up, he was ready to go. Less fatalistic and more realistic were a number of comments which questioned the value of transplanting a healthy heart into a diseased cardio-vascular system.

The Marion panel was also asked: "Do you consider human heart transplant a dramatic surgical advance or the logical outcome of transplant research?" The latter interpretation was given by the overwhelming majority of respondents who felt that the answer to this is the "logical outcome of transplant research." Some 73 per cent of cardiologists and 81 per cent of other doctors were in this category. As might be expected a greater proportion of cardiologists than general doctors believed that human heart transplantation is a surgical advance. This is particularly true of the cardiologists over 65 years old, with 38 per cent of the respondents in the age group indicating surgical advance rather than transplant research.

A recent Gallup poll put the query in reverse form. Would you, at death, be willing to *donate* your heart. Seven out of ten Americans answered "Yes."

American Allergy Academy Picks Jerseyite

The American Academy of Allergy has announced the election of Elliott Middleton, M.D., of Montclair, as Treasurer of this nation-wide body. Dr. Middleton teaches at the Roosevelt Hospital in New York City, and directs the allergy clinic at Mountainside Hospital in Montclair.

Recent Library Acquisitions—Winter 1967-1968

Academy of Medicine of New Jersey

Allergy and Immunology

Anderson, J. R. Autoimmunity, clinical and experimental. Springfield, Thomas, 1966. (Am. Lect. Ser. No. 673. Am. Lect. in Living Chem.)

Basic Sciences

Quiring, D. Head, neck and trunk; muscles and motor points. Phila., Lea and Febiger, 1967. 3rd ed.

Wagner, B. M., ed. Connective tissue. Baltimore, Williams and Wilkins, 1967. (Intern. Acad. of Path. Monog. No. 7)

Cardiovascular System

Rubin, L. L., et al. Treatment of heart disease in the adult. Phila., Lea and Febiger, 1967.

Siddons, H. Cardiac pacemakers. Springfield, Thomas, 1967. (Am. Lect. Ser. No. 680. Am. Lect. in Living Chem.)

Tibblin, G. High blood pressure in men aged 50. Goteborg, 1967. (Thesis-Goteborg).

U.S. National Heart Institute. Coronary drug project. Bethesda, Md., Nat. Heart Institute, 1967.

Dentistry

American Dental Association. Dental students' purchasing guide. Chicago, Am. Dent. Assoc., 1967.

Bregstein, S. Successful practice of dentistry. N.Y., Prentice-Hall, 1953.

McGiffert, R. Brighter writing for dentistry. Chicago, Am. Dent. Assoc., 1966.

O'Brien, W. J. and Ryge, G. Dental materials: a programmed review of selected topics. Phila., Saunders, 1965.

Endocrinology

Ciba Foundation. Human adrenal cortex. Boston, Little, Brown, 1967. (Ciba Fdn. Study Group No. 27)

Eisenstein, A. B., ed. Adrenal cortex . . . Boston, Little, Brown, 1967.

History of Medicine

American Physiological Society. Semicentennial. History of the American physiological society. Baltimore, Md., The Soc., 1938.

Bacon, E. The New York Academy of Dentistry, its first 35 years. New York, New York, Academy of Medicine, 1960.

Barth, R. S. Fiery angel. Coral Gables, Fla., Glade House, 1945.

Bittinger, B. F. Historic sketch of the monument erected in Washington City. Am. Institute of Homeopathy, 1900.

Earle, A. S. Surgery in America. Phila., Saunders, 1965.

Nash, E. B. Leaders in homeopathic therapeutics. Phila., Boericke and Tafel, 1899.

Sinclair, D. A. A bibliography of the civil war and New Jersey. New Brunswick, Friends of the Rutgers Univ. Library, 1968.

U.S. National Library of Medicine. Bibliography of the history of medicine. No. 1. Bethesda, Md., Pub. Health Service, 1965.

Hospital and Hospital Administration

Pennsylvania. Dept. of Health. Ambulance attendant training manual. Harrisburg, Pa., 1967.

Medical Jurisprudence (see also psychiatry)

Wasmuth, C. E., Law for the physician. Phila., Lea and Febiger, 1966.

Medicine as a Profession

Howe, H. F., The physician's career. Chicago, A.M.A., 1967.

Neurology

Epilepsy Foundation. National directory of clinic facilities for the diagnosis and treatment of epilepsy. Wash., D.C., Epilepsy Fdn., 1965.

Norrsell, U. Experimental study of central nervous structures involved in tactile sensibility. Goteborg, 1966. (Thesis-Goteborg)

Peterson, J. C. and Olsen, A. P. Language problems after a stroke: a guide for communication. Minneapolis, Am. Rehab. Fdn., Inc. 1964.

Robb, P. Epilepsy: a review of basic and clinical research. Bethesda, Md., National Inst. of Neurological Diseases and Blindness, 1965. (NINDB Monograph No. 1)

Obstetrics and Gynecology

Beacham, D. W. Synopsis of gynecology. St. Louis, Mosby, 1967.

Kimbrough, R. A. Gynecology. Phila., Lippincott, 1965.

Ortho Pharmaceutical Corp. Raritan, N. J. Understanding conception and contraception. Raritan, N. J., Ortho, 1967.

Rybo, G. Clinical and experimental studies on menstrual blood loss. Goteborg, 1966. (Thesis-Goteborg).

Ophthalmology

Leopold, I. H. Ocular therapy; complications and management. Vol. II. St. Louis, Mosby, 1967.

U.S. National Institute of Neurological Diseases and Blindness. Eye research. Bethesda, Md., Publ. Health Serv., 1967. (Public Health Serv. Publ. 1502)

Orthopedics

Ciba Foundation Symposium Myotatic, kinesthetic and vestibular mechanisms. Boston, Little, Brown, 1967.

Jackson, W. P. U. Calcium metabolism and bone metabolism . . . London, Arnold, 1967.

Waugh, T. R. Intravital measurements during instrumental correction of idiopathic scoliosis. Goteborg, 1966. (Thesis-Goteborg)

Pediatrics (see also psychiatry)

Dittman, L. Children in day care with focus on health. Wash., D.C., U.S. Children's Bur., 1967. (Children's Bur. Publ., No. 444-1967)

Oswin, M. Behavior problems among children with cerebral palsy. Bristol, Wright, 1967.

U.S. National Institute of Mental Health. Red is the color of hurting; planning for children in the hospital, ed. by Milton F. Shore. Bethesda, Md., Nat. Inst. Mental Health, 1967.

Pharmacology and Toxicology

Ciba Foundation Symposium. Drug responses in man. Boston, Little, Brown, 1967.

Handbuch der experimentellen Pharmakologie. Pharmacology of fluorides. Berlin, Springer-Verlag, 1966.

Laurie, P. Drugs; medical, psychological and social facts. Harmondsworth, Penguin Books, 1967.

Seiden, R. Veterinary drugs in current use. N.Y., Springer, 1966. 1st ed. Phila., SK & F, 1967.

Wyeth Laboratories. Sinister garden; a guide to the most common poisonous plants. N. Y., Wyeth, 1966.

Psychiatry

Ackerman, N. W., ed. Expanding theory and practice in family therapy. N. Y., Family Service Assoc. of Am., 1967.

American Psychiatric Association. Biographical directory of the . . . N. Y., Bowker, 1968.

Assoc. of State and Territorial Health Officers. Mental health in the schools. Wash., D.C., The Assoc., 1966.

Berne, E. Games people play N. Y., Grove Press, 1964.

Bolland, J. and Sandler, J. Hampstead psychoanalytic index . . . N. Y., Intern. Univ. Press, 1966.

Davidson, H., Forensic psychiatry. N. Y., Ronald Press, 1965.

Daris, D. R. Introduction to psychopathology. London, Oxford, 1966. 2nd ed.

Heckel, R. V. Psychology . . . St. Louis, Mosby, 1967. 2nd ed.

New Jersey Dept. of Institutions and Agencies. Div. of Mental Retardation. Resources for the retarded in New Jersey. Trenton, N. J., 1967. 5th ed.

New Jersey Mental Retardation Planning Project. New Jersey comprehensive plan to combat mental retardation; recommendations. Trenton, N. J., the Project, 1966.

New Jersey Neuropsychiatric Assoc. Medico-legal almanac for New Jersey psychiatrists. Trenton, N. J. 1966. (Grant from: Charles Pfizer and Co.)

Rodger, T. F. Lecture notes on psychological medicine. London, Livingstone, 1967. 3rd ed.

Walinder, J. Transsexualism; a study of forty-three cases. Goteborg, Elanders, 1967. (Thesis-Goteborg)

Reference Works

Canadian Dental Association. Directory. Toronto, Canada, The Assoc., 1967-68.

College of American Pathologists. Directory — 1968. Chicago, Coll. Am. Pathologists, 1968.

National League for Nurses. Bellevue classifications system for nursing school libraries. N. Y., Nat. League for Nurses, 1965.

Surgery

Bethlehem Corporation. Bethlehem, Penna. Hyperbaric oxygen therapy; hyperbaric oxygenation bibliography through December 1963. Supplements monthly, Bethlehem, Pa., Bethlehem Corp., 1963.

Garlock, J. H. Surgery of the alimentary tract. N. Y., Appleton-Century-Crofts, 1967.

Gifts From Pharmaceutical Company

A physician may not accept a gift such as a radio, compact refrigerator, or the like, from a manufacturer or a distributor of drugs, remedies, appliances or services for prescribing these products for his patients. This is based on an AMA Judicial Council opinion of November, 1967. This practice amounts to rebating. It is ethically improper because it could influence the physician to prescribe the donor's product. If a product or service is prescribed for its effectiveness, it would be preferable that it be discounted so that the patient, rather than the physician, benefits.

ANNOUNCEMENTS

Advances in Coronary Disease

On Wednesday afternoon, May 29th, a symposium will be held at Red Bank, New Jersey, on "Therapeutic Advances in Coronary Disease." Sponsored by the Monmouth County Heart Association, the colloquium will be held at the Molly Pitcher Inn (Riverside Avenue). A distinguished and star-studded faculty will be the essayists and ample time is allowed for questions from the floor. For more details, write to Dr. Leonard S. Danzig, 27 Pinckney Road, Red Bank 07701.

Seminar On Transplantation

September 7th through September 11th will be the dates for the International Congress on Transplantation. The sessions will be held at the Americana Hotel in New York City. For a full program write to Dr. Felix Rappaport, 560 First Avenue, New York City 10016.

ACP Meeting in New Jersey

Wednesday, November 13th is the date and Rutgers University Medical School is the place for the New Jersey Regional Meeting of the American College of Physicians. For details, write to James F. Gleason, M.D., 7 Oxford Avenue, Ventnor City.

Camp For Diabetic Children

Camp Nejeda, our state's camp for diabetic children, is now enrolling campers for the 1968 summer. One session starts on July 7th and the other on July 28th. It is sponsored by, and medically supervised by our brethern in the New Jersey Diabetes Association. The camp is located at Stillwater, New Jersey, four miles west of Newton. For more details, write to Dr. Alfred E. Gras, 153 Roseville Avenue, Newark 07107.

OBITUARIES

Dr. J. Howard Hornberger

Our beloved Past-President, Howard Hornberger, M.D., died on April 3, 1968. He was President of The Medical Society of New Jersey in 1948 and 1949. Dr. Hornberger earned his baccalaureate degree at Bucknell in 1917 and his M.D. at the University of Pennsylvania in 1921. He interned at Philadelphia General Hospital. He went into practice in Burlington County in 1923, and by 1934 he had become President of the Burlington County Medical Society. He became active in the civic life of his area — he was township health office for some years and served as senior physician to the Florence Township Schools. With the enactment of Selective Service in 1939, he became the senior medical officer to the draft system in his region. As a World War I veteran, he was also active in veterans' affairs, and served as commander of the American Legion post in Roebling. Dr. Hornberger was 72 at the time of his death.

Dr. Pasquale Vespignani

At the untimely age of 54, Dr. Pasquale Vespignani died after a brief illness on March 19, 1968. Born in Jersey City in 1914, he was a 1936 graduate of Fordham, and won his M.D. in 1940 at the New York Medical School. He interned at the Christ Hospital in Jersey City in 1941. He entered the Army, serving in General Patton's command, and received several battle stars. He practiced in his native city and was affiliated with all three hospitals there. Dr. Vespignani was, and was proud to be called, a family doctor.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1968
May

8 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Drugs, Poisons, and Membrane Phenomena"

8 **Ocean County Medical Society**

8 **Gloucester County Tuberculosis and Health Association**

8 **Middlesex County Medical Society**

8 **The Academy of Medicine of New Jersey**
Burlington County Memorial Hospital, Mount Holly
Symposium: "Blood Sugar Maintenance and Hypoglycemic States"

8 **The Academy of Medicine of New Jersey — Section on Basic Medical Sciences**
Rutgers — Newark
"Calories, Obesity, and Body Nitrogen"

9 **The Academy of Medicine of New Jersey and Rutgers — The State University**
New Brunswick
The Walter C. Russell Memorial Lecture
"Relations Between Host Nutrition and Resistance to Infection"

9 **Essex County Medical Society**

10 **The Academy of Medicine of New Jersey**
Riverview Hospital, Red Bank
Symposium: "Cancer of Colon and Rectum"

14 **Bergen County Medical Society**

16 **The Academy of Medicine of New Jersey — Section on Radiology**
Newark City Hospital
Radiologic Cases

16 **Morris County Medical Society**

16 **Gloucester County Medical Society**

18-22 **The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Annual Meeting

19 **The Academy of Medicine of New Jersey and The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Symposium on Medicine and Religion

20 **St. Barnabas Medical Center**
Livingston
Conference: "Local Anesthetics — Old Drugs With New Uses"

21 **The Academy of Medicine of New Jersey**
Newcomb Hospital, Vineland
Symposium: "Therapy of Lymphomas"

28 **Cape May County Medical Society**

29 **Monmouth County Heart Assoc.**
Molly Pitcher Inn, Riverside
Symposium: "Therapeutic Advances in Coronary Heart Disease"

29 **Princeton Hospital**
Princeton
Physical Medicine: "Role in Patient Rehabilitation"

June

3-7 **Atlantic City Hospital**
Atlantic City
Visiting Chief Program

6-7 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Culdoscopy

10-14 and 17-21 **Atlantic City Hospital**
Atlantic City
Visiting Chief Program

11 **Ocean County Medical Society**

11 **Bergen County Medical Society**

11 **Cumberland County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"The Thymus — Its Role in Immunity and Disease"

12 **The Academy of Medicine of New Jersey — Section on Psychiatry and Neurology and the New Jersey Association of Social Workers, Northern and Southern Chapters**
East Orange General Hospital
East Orange
"Psychological Therapy and/or Case Workers"

18 **Warren County Medical Society**

20 **Morris County Medical Society**

20 **The Academy of Medicine of New Jersey and the New Jersey State Health Department**
Somerset Hospital
Somerville
Symposium: "Acute and Chronic Care of Alcoholics"

November

13 **The Academy of Medicine of New Jersey**
The Mountainside Hospital
Montclair
Symposium: "Evaluation and Maintenance of a Favorable Fetal Environment"

13 **American College of Physicians New Jersey Regional Meeting**
Rutgers University Medical School
New Brunswick

20 **New Jersey State Dental Society**
Semi-Annual Session

Epilepsy Associations Now Merged

The Epilepsy Foundation and the Epilepsy Association of America have finally merged into one strong, nationwide, voluntary organization devoted to the citizens' struggle against epilepsy. Now called the Epilepsy Foundation of America, the new organization combines the resources of the two previously existing national agencies — each with a network of chapters across the country. This brings new strength to the battle against a disorder that afflicts more than 2,000,000 Americans. Existing chapters of both organizations continue as chapters of the new organization.

A. B. Baker, M.D., chairman of the Medical Advisory Board, reports that plans are underway for "a nationwide action program that will end epilepsy's status as America's single most-neglected health problem." He suggests that epilepsy patients are presently faced with medical, social, educational, economic, and legal problems that have cost the nation hundreds of millions of dollars and robbed almost every epileptic of his dignity and self-respect. Dr. Baker calls on physicians to join wholeheartedly in a massive effort to bring epilepsy to the nation's attention. The goal of the new Foundation is nothing less than "total victory over a disorder that has been scandalously ignored for centuries."

For more information, write to the Epilepsy Foundation, 1419 H Street, Washington, D.C.

BOOK REVIEWS

Principles Of Nuclear Medicine. Edited by Henry N. Wagner, Jr., M.D. Philadelphia, 1968, Saunders. Pp. 896. Illustrated. ($27.50)

Why would a new textbook be offered with only minimal promotion and omitting the usual blurb-filled dust jacket? The answer is probably confidence in the book itself, which really fills a need for a solid text in a precocious and new branch of medical practice. In the text, much of the material is probably beyond the grasp and curriculum of the average medical student or intern. Dr. Wagner and his 24 prominent contributors have assembled a classic reference work covering the entire field of nuclear medicine, sufficient for the needs of an advanced resident in radiology, the practicing clinician and the research investigator.

The book opens with the foundational material needed in nuclear medicine: mathematics, statistics, basic physics, measurement of radioactivity, radiophamaceutical matters, and so on. There is an excellent section on equipment. One minor disappointment was the absence of actual instruction for the physician who might wish to calibrate and check on the reliability of his own instruments rather than place complete trust in others. Ten chapters cover clinical application of radioactive isotopes to specific organs and systems. The busy practitioner could find the book worthwhile, if he starts reading it at this point.

Individual chapters are so complete and technically correct that even a specialized physician such as the thyroidologist or a neurosurgeon might acquire this book just for one pertinent chapter. There are thirty-two brain scan illustrations, and one wishes the editor had space for more. The brain, after all is the hardest area to scan and interpret. On the other hand, the forty some lung scan illustrations are delightfully adequate. These ten sections are, in some cases, so far ahead, that several writers from teaching institutions, describe as their proved routine the use of a specific radioactive isotope not yet licensed by the Atomic Energy Commission for generalized use. In fairness, however, the same authors cover in full detail those earlier isotopes still in use in the average smaller community hospital.

The last six chapters cover closely related items such as radiation injury, dosimetry, safety, *in vitro* tests, and technical details of common procedures. The comments on setting up a protection program and the keeping of records are most useful in this day when federal and state agencies keep a close watch on the use of radiation from nuclear by-products; and on how and why the public is being exposed.

There is no other book with which to compare, since the only similar text (a fine two-volume set) last revised in 1963, provided material now six or seven years out of date, in a field where the most useful application (Organ Scintiscanning) has been in wide use only about five years. Between 1963 and the recent publication of *Principles of Nuclear Medicine,* one's total current library on isotope scanning consisted of a loose collection of reprints and small monographs. But now this book should surely become a required item for the worker in nuclear medicine or for one planning to set up an isotope program in a private practice or hospital. Let us hope that the editor will be able to remain abreast with this new, fast moving branch of medicine by providing frequent revised editions as the science grows. SYDNEY B. LEWIS, M.D.

Fidelity and Infidelity. Leon J. Saul, M.D., Philadelphia, 1967, Lippincott. Pp. 244. ($5.95).

Marital conflict is always, the man says, due to the acting out of childhood patterns. The author repeats this, in many forms: "We trace this to the restrictive dominating matriarchy of childhood." Or, "the pattern of hostility was caused by a tyrannical father." If childhood relationships seemed good, how does he account for marital unhappiness later? Simple, "A person may have relationships with his parents that seem good, but there may be important tensions beneath the surface." It's always the parents fault: they can't win. We are reminded that "reacting to the dramatis personae of one's childhood lives on in all of us." Page after page repeats the theme: "the old emotional patterns of child to parents . . . tend to emerge." Again: "The really determining cause lay in severe neglect by his mother."

If childhood patterns are so deeply etched into the adult, how can any person escape the ill-effects? Well, "the basic emotional difficulties are frequently found to be perfectly solvable." And even better, "a blitz analysis" is described in which "one burst of insight enabled masculine pride to conquer dependence."

The parents are not only responsible for making their children neurotic or hostile, but "all neurosis, psychosis, addiction, crime, and war" are traced to the same roots.

Infidelity occurs "only when the triangle fits a pre-existing childhood pattern."

As you see, it's all very simple.

HENRY A. DAVIDSON, M.D.

Black Market Medicine. Margaret Kreig. New York, 1967. Bantam Books. Pp. 309. (Paper back, $0.95)

Unknown to most of us, there exists in this country a flourishing, if undercover, black-market drug industry. Although not employed by the Food and Drug Administration, Mrs. Kreig actually participated in many of their operations. Some of the criminals who were reaping the profits apparently played for keeps and the author's life and the lives of FDA inspectors were sometimes in jeopardy. Racketeers apparently get fake medications and apply counterfeit labels. They use contaminated or distressed drugs. They get samples. They dilute or water genuine liquids. They change the expiration dates on stale medications. They hijack legitimate shipments. The way in which the racketeers and their rackets are tracked down is spelled out in full, and sometimes gruesome detail. There are sections on drug identification, on FDA organization, on wiretapping, bugging, briefing, debriefing, counterfeiting, generic names, and so on. Many patients are going to read this modestly priced (95¢) paperback — and maybe the doctor had better know about it too.

ULYSSES M. FRANK, M.D.

The Prevention of Highway Injury. Edited by Melvin I. Selzer, M.D., Paul W. Gikas, M.D., and Donald F. Huelke, Ph.D. Ann Arbor, Michigan, 1967, Highway Safety Research Institute, University of Michigan, Pp. 293. Illustrations ($6.50)

How many of us have cried (inwardly, if not outwardly) upon seeing a patient in the office or in the hospital injured in an automobile "accident?" And how many times have we thought what might have been done to prevent such an injury? The University of Michigan is to be commended for sponsoring a recent symposium, the papers of which are published in this new book. At long last, our nation is beginning a serious effort to reduce the enormous highway toll in lives and human suffering. Some of the material in the book has been presented at various surgical meetings. Now, however, we have the opportunity to peruse at our leisure, in an excellently presented form, the results of a tremendous amount of research in this increasingly important field. In considerable depth, various aspects of automobile accidents are covered with the broad titles of "The Alcoholic Driver," "Vision and Medical Impairment," "Biomechanics," and "The Second Collision." Thus, we are apprised of most of the measurable aspects concerning the human factor in driving, as well as the mechanical factors of the vehicle itself. There are even critical evaluations of the construction of highways. This book belongs on all reference shelves, not only in libraries but in the offices of any physician who helps care for patients having sustained automobile trauma—perhaps even on the shelves of anyone who drives an automobile. The physician will better be able to understand the how and why of the injury he is treating, and better be able to counsel his patients (and himself) concerning the prevention of further injuries. Dr. Selzer says in his preface "The papers in this volume confirmed our view that accidents and injuries can be sufficiently reduced now — *if only we make the effort.*" The italics are mine, and I can only add, "Amen."

EDWARD N. LUDIN, M.D.

Treatment of Meningitis, William S. Fields, M.D., Editor. **Treatment of Mental Retardation, Part II,** Charles M. Poser, M.D., Editor. (Modern Treatment, Vol. 4, #5) New York, 1967, Hoeber Medical Division, Harper and Row. ($16 per year by subscription)

The "meningitis" part of this starts with specific instructions to the physician as to "what to do until the laboratory reports come back." These instructions include details of lifesaving supportive therapy to be used immediately. Then follows a description of general procedures in obtaining and examining cerebrospinal fluid. There is a thorough discussion of the ways the laboratory hunts down the responsible organism with the end in view of handing the therapist a comprehensive "profile" to use in mounting the final therapy. The treatment of each type of meningitis is then discussed, tying in the etiologic agent with the proper bacteriostatic or bacteriocidal drug and its mode of administration.

The second half of the book deals with metabolic and endocrine causes of mental retardation. This is a little more difficult to follow because of the relative newness of the subject. The hope is, that by specific treatment, prevention or reversal of retardation can occur. Also, they offer a good discussion of the hereditary, metabolic, and endocrine disorders which are enzymatic defects. The text pleads for early recognition of inherited or acquired metabolic and endocrine disorders to prevent possible neurologic sequelae.

The biochemical symptom complexes, with the clinical features of each, are well reviewed so that the therapist may perform the appropriate confirmatory tests and institute specific therapy. RALPH N. SHAPIRO, M.D.

Cardiac Radiology. Edward F. Dunne, M.D., Philadelphia, 1967, Lea and Febiger. Pp. 256. Illustrated. ($12.50)

The author has thoroughly and concisely discussed the radiology of cardiac valve disease culled from a busy decade of personal experience. Hypertension, arteriosclerosis, and certain rare congenital anomalies not personally encountered are excluded. Simple x-ray methods are stressed and the pictures carefully analyzed in terms of lesion, pressure, and volume changes. Easily read, the type is large and the language terse and unadorned. The book is not encyclopedic and is not intended as a primer for learning how to read cardiac x-rays. In this book, the x-rays are pictured largely without arrows or other diagrammatic aids. However, this worthwhile volume will be of great interest to clinicians interested in cardiology.

NORMAN RIEGEL, M.D.

The Biology of Dreaming. Ernest Hartmann, M.D. Springfield, Illinois, 1967, C. C. Thomas. Pp. 206. With 656 references. ($9.75)

Dreaming is here considered a purely biologic phenomenon characterized by five or six ninety minute cycles a night. During this cycle the person is capable of dreaming. The state during which dreams may occur is here designated the D state, which is part of stage 1 of sleep, associated with rapid eye movements and a characteristic electroencephalographic pattern. It is, ontologically, a primitive state, and the fetus *in utero* spends much of his time in a D state which resembles the waking state more than the phase of deep sleep. The pons appears to be the site of origin of the D state. It is associated with tonic muscular inhibition and a reduction in the input of external stimuli. If an individual (or animal) is deprived of his D state (by wakening him as it starts) he develops a craving for it and makes up the lost time.

Hartmann has something to say about the chemistry of the D state: acetyl choline and serotonin, both of which play a role in maintaining the D state. The D phase is one of the body's basic cycles, clearly related to the subject's metabolic state. The D period is correlated with anxiety but not with sleep talking (which typically occurs during deep sleep). Most sleep talking is entirely unrelated to dreaming at that time. The author does not agree with Freud that the dream is the preserver of sleep, since sleep-disturbing (wakefulness-producing) stimuli never provoke a dream. It is even possible that the persistent 90-minute D cycle occurs during waking hours as well as during sleep. It is probably under humoral control.

This text is a serious review of the D state. The emotional *meaning* of the dream is here ignored with the implication that the dream is a biologic phenomenon of no emotional significance The book is clearly written, modest in its claims, but firm in its purely biologic interpretation of dreams. L. J. BARONE, M.D.



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There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

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Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



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"The danger involved in prescribing dependency producing medication for relief of anxiety lies in the fact that we do not know in advance the dependency proneness of the individual."[1]

A woman who is undergoing the emotional stresses of the menopause may, for the first time, need an antianxiety agent. But she may also be susceptible to drug abuse.

Vistaril can fulfill the need for tranquilization without creating a new need—dependency.

Vistaril calms anxiety and agitation quickly—usually begins to work in 15-30 minutes. And, in more than ten years of clinical use, after more than a billion doses to date, there have been no reported instances of dependency on hydroxyzine.

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With Vistaril, it is as easy to stop therapy as it is to start.



Contraindications: Hypersensitivity to hydroxyzine. The parenteral solution, for intramuscular or intravenous use, *must not* be injected subcutaneously or intra-arterially.

Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit induced fetal abnormalities in the rat at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate. Until adequate data are available to establish safety in early pregnancy, hydroxyzine is contraindicated during this period.

Precautions: Hydroxyzine may potentiate the action of central nervous system depressants such as narcotics and barbiturates. In conjunctive use, dosage for these drugs should be decreased as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. The usual precautions for intramuscular injection should be followed; soft-tissue reactions have rarely been reported when proper technique has been used. Hydroxyzine parenteral solution for intramuscular use should be injected well within the body of a relatively large muscle. In adults, the preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. In children, preferably the mid-lateral muscle of the thigh. In infants and small children the upper outer quadrant of the gluteal region should only be used when necessary, as in burn patients, in order to minimize the possibility of damage to the sciatic nerve. The deltoid area should be used only if well developed, such as in certain adults and older children, and only with caution to avoid radial nerve injury. Injections should not be made in the lower and middle thirds of the upper arm. Aspiration should be done to help avoid intravascular injection. On reported intravenous injection a few instances of digital gangrene have occurred distal to the injection site, considered to be due to inadvertent intra-arterial injection or possibly periarterial extravasation. Therefore, particular caution (aspiration and site injection) should be observed to insure injection only into intact veins; avoid either intra-arterial injection or extravasation. Intravenous administration should be accomplished slowly, no faster than 25 mg. per minute, and not to exceed 100 mg. in any single dose. In order to avoid possible adverse effects it is recommended that hydroxyzine parenteral solution be diluted to at least 50 cc. with sterile normal saline and administered over a period of four minutes or more, preferably into the tubing of a running intravenous infusion.

The intravenous administration of this drug is not recommended for children under 12 years of age.

Adverse Reactions: Drowsiness may occur; if so, it is usually transitory and may disappear in a few days of continued therapy or upon dosage reduction. Dryness of the mouth may occur with higher doses. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with higher than recommended dosage.

When this product is given intravenously undiluted, minimal amounts of intravascular hemolysis occur at the site of injection. Giving the maximum recommended intravenous dose (100 mg.) to adults results in immediate transient hemolysis with the liberation of a total of 2-3 grams of hemoglobin, which, in some individuals, can cause small amounts of hemoglobinuria. This compares with the normal red cell destruction from which approximately 8 Gm. of hemoglobin are liberated every 24 hours. If the hydroxyzine is diluted with 50 cc. of normal saline and given during a period of four minutes or more, this phenomenon does not occur.

Supply: Vistaril (hydroxyzine pamoate) Capsules: Equivalent to 25 mg., 50 mg., 100 mg. hydroxyzine HCl. Vistaril (hydroxyzine pamoate) Oral Suspension: Equivalent to 25 mg. hydroxyzine HCl per 5 cc. teaspoonful. Vistaril (hydroxyzine HCl) Parenteral Solution: 25 mg./cc.—10 cc. vial and 50 mg./cc.—2 cc. and 10 cc. vial; Isoject,® 25 and 50 mg. per cc., 1 cc. per unit.

More detailed professional information available on request.

References: 1. Greenhouse, H.R.: Medication and the Dependent Personality, Symposium of Non-Narcotic Drug Dependency and Addiction, The Amer. Psychiat. Assn., N.Y. County Dist. Branch, New York, N.Y., March 10, 1966.

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burning
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discharge
of trichomonal vaginitis...

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For the most widespread form of vaginitis the most widely successful therapeutic agent, Flagyl, is clearly indicated.

In trichomonal vaginitis, most physicians have reported a cure-rate of 95 per cent or more with Flagyl when infected male partners are treated concurrently and when treatment is repeated for occasional refractory infections in women.

Among the few patients who do not respond to Flagyl are those who may not have taken the prescribed dosage and those who may have been reinfected.

This high rate of cure obtained with Flagyl is unparalleled. Only systemically active Flagyl reaches the hidden reservoirs of reinfection in male and female genitourinary tracts.

Indications: Flagyl is indicated only in the treatment of trichomoniasis in both the male and female.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

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FACT & LEGEND



GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS, 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.

NAPOLÉON BONAPARTE

LOST THE BATTLE OF WATERLOO BECAUSE HE WAS TOO FAT!

ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.





THE BOOK **"PRAY YOUR WEIGHT AWAY"** URGES READERS TO "ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.

DIET DROPOUTS ACCORDING TO DRS. SHIPMAN AND PLESSET "APPARENTLY NO DIETER SUCCEEDS WHO IS VERY ANXIOUS OR DEPRESSED."* THE AMBAR FORMULA PROVIDES **METHAMPHETAMINE** TO HELP **ELEVATE** THE **MOOD** AND **PHENOBARBITAL** TO HELP REDUCE **ANXIETY**

*SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963)

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

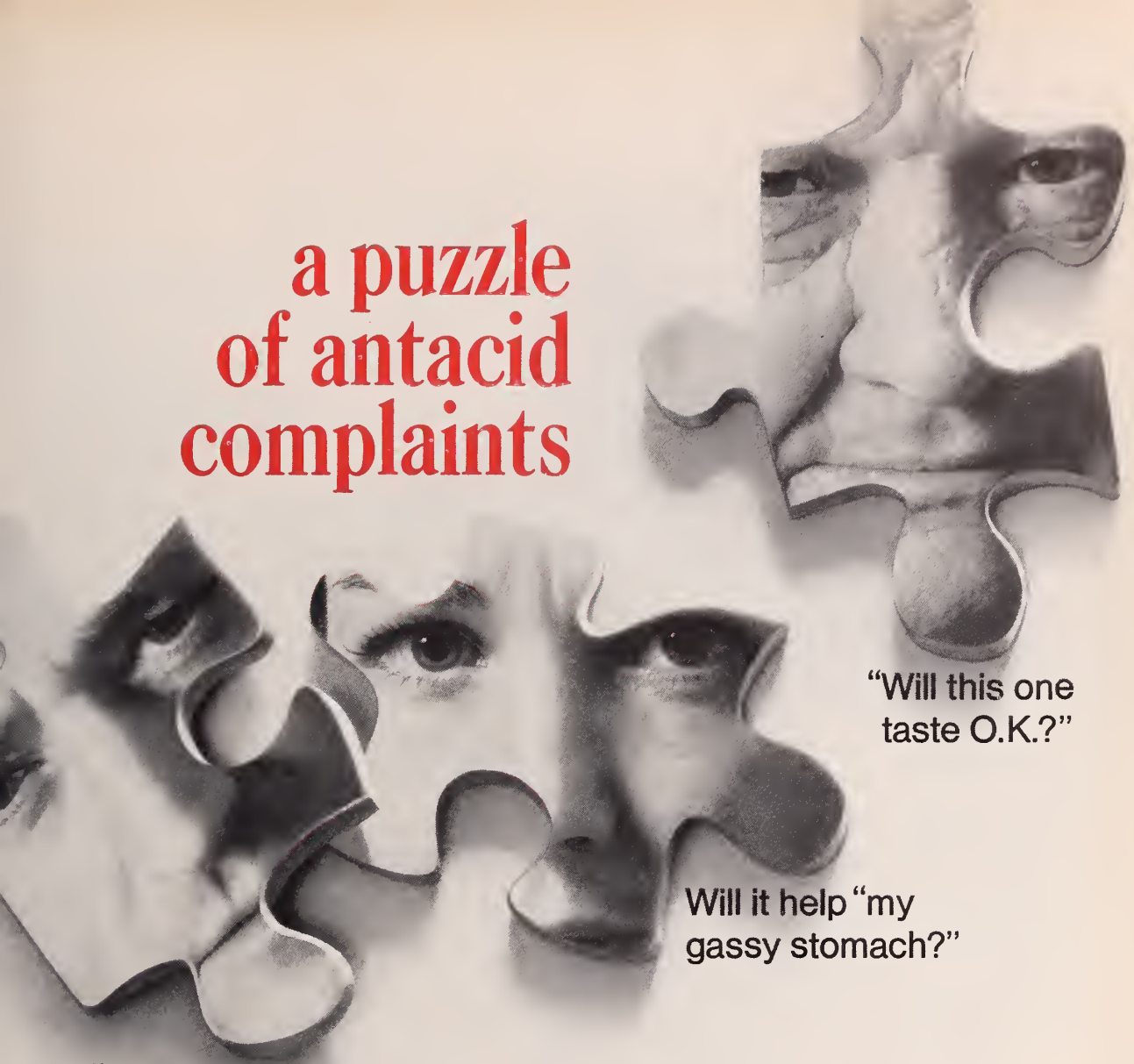
One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Am suppresses appetite and helps offset e tional reactions to dieting. **Contraindi tions:** Hypersensitivity to barbiturates sympathomimetics; patients with advan renal or hepatic disease. **Precautions:** Administer with c tion in the presence of cardiovascular disease or hypertensi **Side Effects:** Nervousness or excitement occasionally no but usually infrequent at recommended dosages. Slight dro iness has been reported rarely. See package insert for full details.

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Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg.
Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I.E., Personal communication.

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When the agitated geriatric disrupts the home...

His daughter can't please him. There is "just no living with him."

His disturbances at the table make every meal a nightmare.

His teen-age granddaughter won't invite friends home because of his outbursts.

His slovenly room and hab create more tension.



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- Mellaril helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
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- Mellaril helps the patient maintain realistic contact with environment, closer harmony with family

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, a pine, and phosphorus insecticides. Where complete mental al ness is required, administer the drug cautiously and incre dosage gradually. In addition, orthostatic hypotension (espec ly in female patients) has been observ Epinephrine should be avoided in tr ment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism a other extrapyramidal disorders are frequent; drowsiness, especially in h doses early in treatment, may occ nocturnal confusion, dryness of mouth, nasal stuffiness, headache, ripheral edema, lactation, galactorrh and inhibition of ejaculation are no on occasion; photosensitivity and ot allergic skin reactions may occur but extremely rare.

for moderate to severe anxiety

Mellaril®

(thioridazine)

25 mg. t.i.d.

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Before prescribing, see package insert for full product information.

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Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In bacterial/allergic u.r.i., ACHROCIDIN brings the treatment together in a single prescription —prompt relief of headache and congestion together with effective control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.
Contraindications: History of hypersensitivity to any component.
Warning: If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment, which should be discontinued at first evidence of skin discomfort.
Precautions: Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development may cause discoloration of teeth.
Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels following full therapeutic dosage has been reported. This has disappeared rapidly when drug was discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy and in children given the drug during the neonatal period, infancy, and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

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The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
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Phenobarbital, Caution: May be habit forming	21 mg.
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Precautions: Usual for aminophylline-ephedrine phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

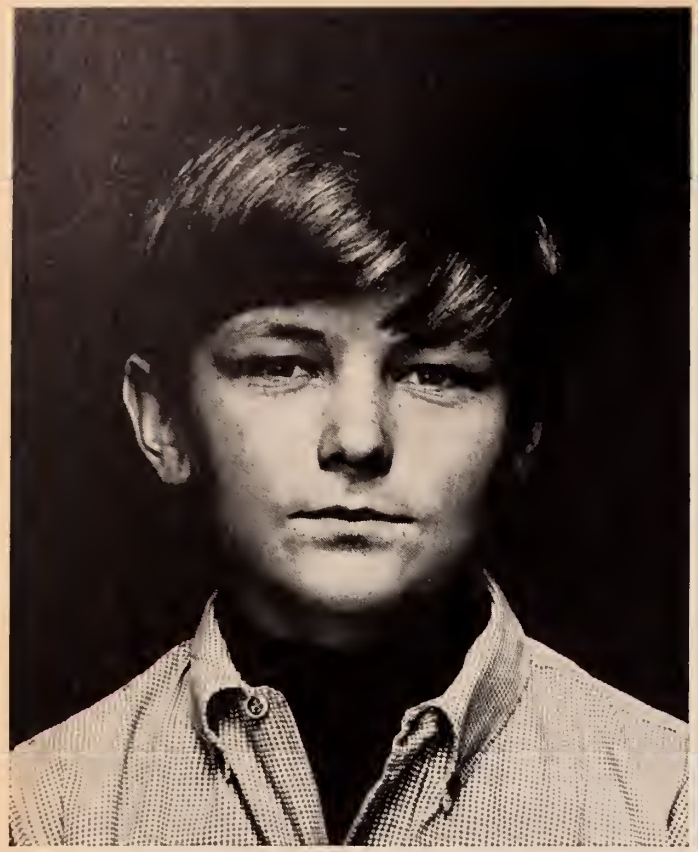
One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

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Just forget your keys in your car one day.

Tempt some fourteen-year-old boy into going for a joyride.

Oh, he could be a good kid — just weak.

And taking your car might be the first time he's ever broken the law.

But the minute he hops behind that wheel and turns the key, his life may be ruined.

He'll drive around for a few hours, endangering the life of every man, woman and child who crosses his path.

He might be caught the very first time he takes a car. Or if he's not caught by the police he'll leave your car somewhere and decide to do it again, and again, until the day he does get caught.

Teen-agers steal more than 1,000 cars every day.

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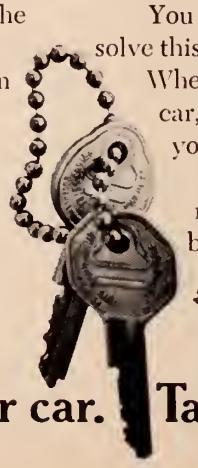
They know that taking a car for a joyride is just the first step.

Our prisons are filled with men who started out this way. They went on to become thieves, muggers, and even killers.

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Whenever you get out of your car, even for a second, take your keys. Lock your car.

Every time you do this you may keep a good boy from going bad.



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What's your basis of choice for therapy of edema in congestive heart failure?

Sodium retention and edema are nearly universal problems in congestive heart failure—and diuretic therapy the generally accepted solution. In this situation HYDROMOX* (Quinethazone) produces quick and thorough diuresis—comparable in every way to that produced by the thiazides.

If other agents may often be equally effective, why then prescribe HYDROMOX? *Because it has worked for certain patients in whom thiazides have failed.* The Na/K excretion ratio is relatively high (4.5-6.2:1)—which means that the possibility of potassium depletion is reduced. And it usually brings about the desired effect on only one dose a day.

Hydromox* Tablets
Quinethazone

Precautions: Electrolyte abnormalities may be aggravated or produced. Caution is important during prolonged or intensive therapy and when salt intake is restricted. Hypokalemia has been mild and infrequent, and other electrolyte abnormalities rare. The possibility of potassium depletion and its toxic sequelae must be kept in mind, particularly in cirrhotics and patients receiving digitalis. As a preventive measure the use of foods rich in potassium, such as orange juice, may be desirable.

Although not a thiazide, HYDROMOX may possess certain characteristics of the thiazides. They have been known to cause jaundice with liver involvement and pancreatitis; hematological complications such as purpura with or without thrombocytopenia and leukopenia (neutropenia); increases of serum uric acid; decreased glucose tolerance as evidenced by hyperglycemia and glycosuria thus aggravating or provoking diabetes mellitus and azotemia in patients with renal disease; photoallergy. Discontinue use a few days prior to elective surgery. When added to a regimen that includes ganglionic-blocking agents, the dosage of these latter preparations should be reduced. Also reduce dosage when one or more of these antihypertensive agents is added to an established HYDROMOX regimen. Contraindicated in anuria. Observe for possible hematologic complications.

Side Effects: Skin rash; gastrointestinal disturbances (chiefly nausea), weakness, dizziness. These seldom require cessation of therapy, and can be relieved by reducing dosage or correcting electrolyte imbalance.

Warning: Enteric coated potassium tablets have been implicated in small bowel lesions and should be used only when adequate dietary supplementation is not practical.

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387-8



Indications: Tofrānil is recommended for the treatment of depressive states of diverse psychopathology.
Contraindications: The concomitant use of Tofrānil and monoamine oxidase inhibiting (M.A.O.I.) compounds is contraindicated. Hyperpyretic crises or severe convulsive seizures may occur. Potentiation of adverse effects can be serious or even fatal. An interval of at least 7 days after M.A.O.I. therapy has been discontinued should be allowed before Tofrānil may be substituted. Initial Tofrānil dosage should be low, increases should be gradual, and the patient's progress should be carefully observed.
Warning: Clinical reports have suggested that there may be a risk of teratogenesis associated with the use of this compound during the first trimester of pregnancy. Unless, in the opinion of the prescribing physician, the potential benefits outweigh the possible risks, Tofrānil should not be used during the first trimester of pregnancy.
Cardiovascular complications, including myocardial infarction and arrhythmias, have occasionally occurred in susceptible individuals. Patients with cardiovascular disease should be given the drug only under careful observation and in low dosage.
Precautions: Since suicide is always a possibility in severely depressed patients and one which may persist until significant remission occurs, such patients should be carefully supervised during early treatment with Tofrānil. Some severely depressed patients may also require hospitalization and/or concomitant electroconvulsive therapy.
Because of its anticholinergic effect, caution should be observed in prescribing Tofrānil for patients with increased intraocular pressure.
In rare instances, transient cardiac arrhythmias have occurred in hyperthyroid patients and in patients receiving thyroid medication when Tofrānil was added to the regimen.
Imipramine may block the pharmacologic activity of guanethidine and other related adrenergic neuron-blocking agents.
The drug is not recommended at the present time in patients under 12 yea of age.
Adverse Reactions: Dryness of the mouth, tachycardia, constipation, dis turbances of accommodation, sweating, dizziness, weight gain, urinary frequency or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis i schizophrenics and agitation (includ-

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Toxic reactions severe enough to require discontinuation of Tofrānil are uncommon. However, for complete details, please refer to the full prescribing information.

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Geigy

pomanic and manic episodes) may require dosage reduction r addition of a tranquilizer or rary discontinuation of the drug, tiform seizures, orthostatic ension and substantial blood ure fall in hypertensive patients, ra, transient jaundice, bone marepression including agranulocysensitization and skin rash ing photosensitization, eosinoand mild withdrawal symptoms lden discontinuation after prod treatment with high doses. ional hormonal effects (imce, decreased libido, and estroeffects) may be observed. ne-like effects may be more unced (e.g. paralytic ileus) in otible patients and in those anticholinergic agents (includtiparkinsonism drugs).
ient Adult Dosage: Initially, dally, increased, if necessary, to 150 or 200 mg. Maintenance dosage may be lower, 50 to 150 mg. daily, if possible.
Geriatric and Adolescent Dosage: Initially, 30 or 40 mg. daily, which may be increased according to response and tolerance. It is usually unnecessary to exceed 100 mg. daily.
A lag in therapeutic response, lasting from a few days to a few weeks, should be expected. When dosage recommendations are already being followed, increasing the dosage does not normally shorten this latency period and may increase the incidence of adverse reactions.
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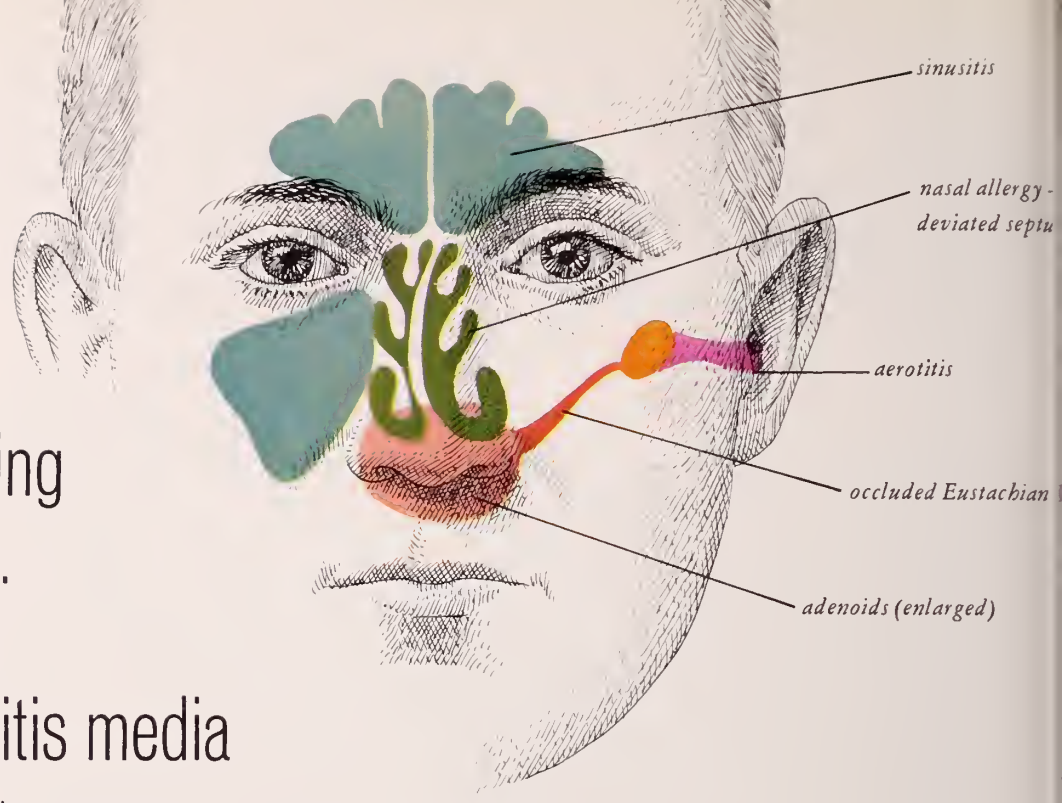
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this issue:
serous otitis media
an original article
by Robert H. Lofgren, M.D.



the complaining earache... key to serous otitis media

Robert H. Lofgren, M.D.
Associate Surgeon, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts

Serous otitis media is probably the most common ear problem in children, especially in the wintertime. Diagnosis is usually easy in adults, but may be quite difficult in children, especially the very young child where one has to depend almost entirely on the physical findings.

The symptoms of serous otitis are a fullness in the ear, a mild hearing loss and mild earache. The earache can best be described as a "complaining earache" instead of a "screaming earache" as found in purulent otitis media. A young child may be irritable and pull at the ear. In milder cases, and as the ear recovers, gurgling and popping noises can be heard in the ear.

On examination one may see a yellow tympanic membrane and if a fluid level is present the diagnosis becomes easy. However, the eardrum may be dull gray, or slightly pink, or even perfectly normal. Pneumomassage using a Siegle otoscope or a closed-head electric otoscope must be done on both ears, otherwise the diagnosis will be frequently missed. Attempted movement of the drum with the pneumatic otoscope produces either a sluggish motion of the drum or no motion at all instead of the easily movable normal drum. The Rinne test is negative and there is a 15-20 decibel conductive hearing loss. The bone conduction may be better than normal and an air-bone gap may exist even with the air conduction within normal limits. Occasionally one finds a false nerve deafness on the audiogram when thick glue-like fluid causes immobility of both the oval and round window. Both conditions return to normal when the fluid is removed, but they make the interpretation of screening audiograms very difficult.

There is no single cause for serous otitis. One factor always present is blockage of the eustachian tube, but this alone is not enough to produce fluid. There must also be an inflammatory reaction. Blockage of the eustachian tube may be caused by many conditions. In children the most common cause is enlarged adenoids. In the summer the next most common cause is allergy. Upper respiratory infections or influenza are common causes in the winter. Nasal allergy, acute and chronic sinusitis, nasal septal deformity and cleft palate can all cause eustachian tube obstruction. Some children may have a congenitally small eustachian tube, but fortunately they usually "grow out of the problem."

The first sign of a nasopharyngeal tumor is often a serous otitis. One must always rule this out in any adult who later in life develops repeated or persisting serous otitis. Causes sometimes overlooked are nasogastric tubes after surgery, simple obesity and cardiorenal disease, which may produce congestion in the mucosal lining of the eustachian tube. In recent years we have been seeing a new cause—acute otitis media, where the patient is adequately treated with antibiotics but where drainage has not been

established either through the eardrum or down the eustachian tube. A sterile exudate is left in the middle ear.

The inflammatory response may be caused by a marked negative pressure as in air otitis from flying, or it may be from a mild bacterial or viral infection in the middle ear. Serous fluid is a good culture medium and will frequently go on to purulent otitis media, especially if the original blockage was caused by an infectious process such as acute rhinitis or adenoiditis. When the infection heals there may be scarring in the middle ear mucosa. Mucous glands develop in this tissue and pour out a thick mucoid material. This ear usually looks normal until a pneumatic otoscope is used. The objectives in treating serous otitis are to remove the obstructing agent and to provide drainage from the middle ear. Often this can be accomplished by decongestants and nose drops. If large obstructing adenoids are present they should be removed. Sinusitis should be treated with oral decongestants or nose drops, plus antibiotics where indicated. Nasopharyngeal tumors should be treated. Allergies should be treated with antihistamines and, where indicated, by desensitization.

If the fluid does not clear with medical treatment within a week or two, a myringotomy should be done. If there is a question of active infection or if the fluid looks purulent, as is seen at the conclusion of acute otitis, cultures are taken. On adults this can be done in the office without anesthesia. It is no more painful than an intravenous needle for a blood test. A good safe topical anesthetic has a tremendous psychological value to the patient. Children under the age of 1 require no anesthesia. Between the ages of 1 and 3 anesthesia is not absolutely essential although a general anesthetic may be used to avoid the child's possible mistrust at follow-up examinations. I usually do the myringotomy at the same time as the adenoidectomy if the adenoids are enlarged. Once drainage has been established with decongestants or by myringotomy, positive pressure inflation of the middle ear is invaluable in forcing out the serous fluid and keeping it from reforming. The patient can do this himself by performing the Valsalva maneuver. This should be done several times a day, by taking a deep breath, holding the nose and blowing hard against the closed lips for a second or two.

In resistant cases where the fluid reforms as soon as the myringotomy heals, small polyethylene tubes are inserted through the myringotomy site. Insertion of the tubes, even in adults, usually requires an anesthetic. Good anesthesia can be obtained by infiltrating the canal wall with a local anesthetic, using a #27 needle. Once inserted the patient has no sensation of the tubes' presence. Be careful to caution the patient or parents not to allow any water to get into the ear canal while a myringotomy is open or a tube is in place. Water can be kept out by a pledget of lamb's wool in the ear canal or a cotton pledget thickly coated on the outside with petroleum jelly. I check these patients a week after a myringotomy to be sure it is healed and at two month intervals until the tubes have fallen out, usually within three to six months after insertion.

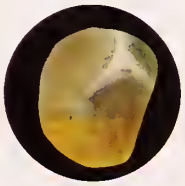
The mucoid type of fluid is so thick and tenacious that it is appropriately called a glue ear. It is aspirated only with difficulty through the eardrum, and occasionally must be removed through a tympanotomy. This thick, glue-like fluid is prone to recur, as the myringotomy usually heals long before the mucous membrane has returned to normal. Repeated myringotomies, as many as ten or twenty, were formerly required for this condition. Now polyethylene tubes are inserted initially when this thick, glue-like material is found. At times a subacute mastoiditis may accompany the serous otitis, which will necessitate a simple mastoidectomy before the condition can be eradicated. Usually the thin serous fluid readily responds to decongestants or to a myringotomy and removal of the eustachian tube obstruction. Occasionally, however, even serous fluid will repeatedly reform. For this, resection of the tympanic plexus of nerves which lies on the promontory of the middle ear has been carried out, as the tympanic branch of the glossopharyngeal nerve is the secretomotor nerve to the ear.

Failure to diagnose serous otitis is the most common cause of the recurrent, almost continuous otitis me-

Otoscopic Views



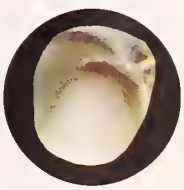
Normal



Acute Serous



Acute Purulent



Chronic Serous

dia seen in young children. In these cases a myringotomy will frequently provide a long-term cure without adenoidectomy or any other surgery. Failure to do this may allow the condition to go on to acute or subacute mastoiditis. Adhesive otitis media with scar tissue binding down the ossicles or tympanosclerosis may also result with permanent impairment of hearing. The prognosis for hearing with adhesive otitis or tympanosclerosis is usually poor. If the adhesions are removed, they reform, and the same is frequently true of tympanosclerosis even after a tympanoplasty. For many of these people a hearing aid is the only solution. The constant negative pressure in long standing serous otitis media may draw in either Schrapnell's membrane or the posterior superior portion of the eardrum forming a pocket to cause a chronic otitis media with cholesteatoma, which may not become apparent until twenty or thirty years later.

The non-medical complications of improper diagnosis or treatment may be even more serious. The irritable child, the frequent bouts of acute purulent otitis media with pain and fever, the expense of antibiotics and doctors, and the time lost from school or work affect the entire family.

In summary, serous otitis has many causes. There is a blocking of the eustachian tube and an inflammatory reaction in the middle ear mucosa, the latter usually caused by a mild infection. The treatment is to provide immediate drainage by decongestants and where necessary, by a myringotomy. The obstructing agent must be removed by surgery if it is adenoid or by oral decongestants, and antihistamines or nasal spray if it is an upper respiratory infection or allergy. Occasionally resistant cases require plastic tubes placed through the eardrum or other more radical surgery. Failure to treat properly leads to hearing loss which may be permanent, repeated acute otitis media or possibly even chronic otitis media with cholesteatoma.

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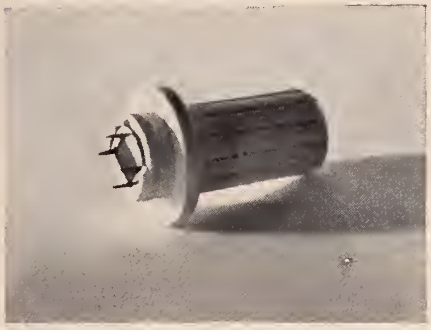
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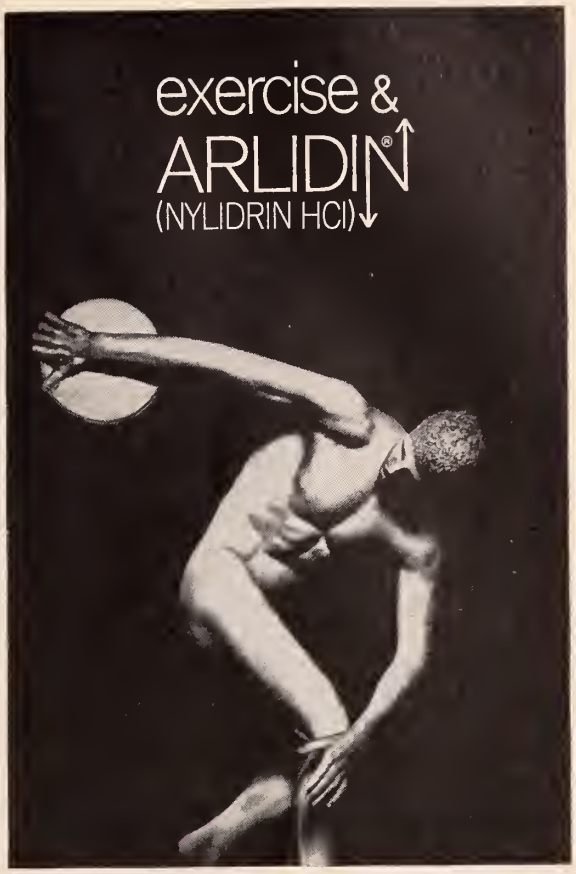


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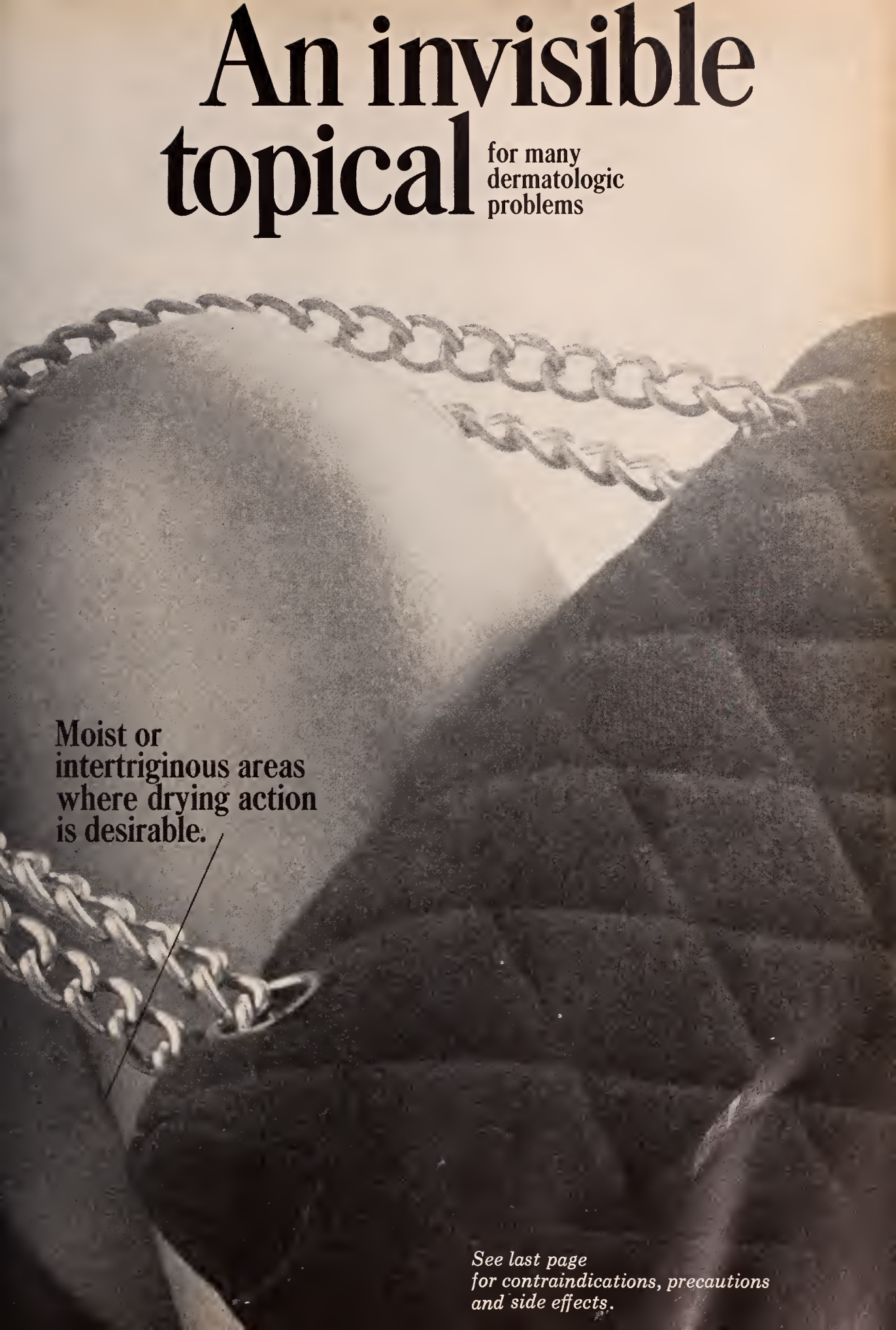
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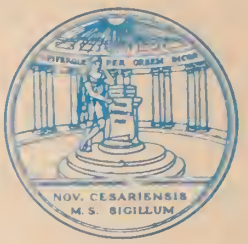
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THE JOURNAL is published monthly (since 1904) by The Medical Society of New Jersey — under the direction of the Publication Committee — 315 West State Street, Trenton, New Jersey. Phone: 394-3154 (Area Code 609); Printed and Published at Periodical Press, 3rd and Hunting Park Avenues, Philadelphia, Pennsylvania.

SUBSCRIPTION RATES — Price per year in advance, including postage: United States, $5. Foreign, $5, plus postage.

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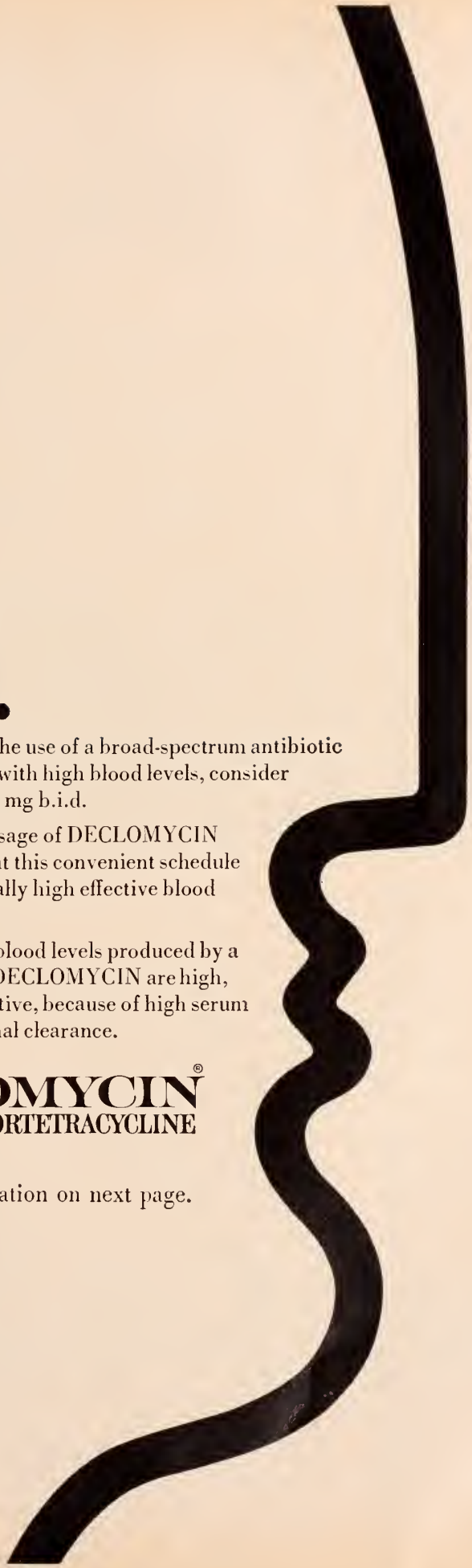
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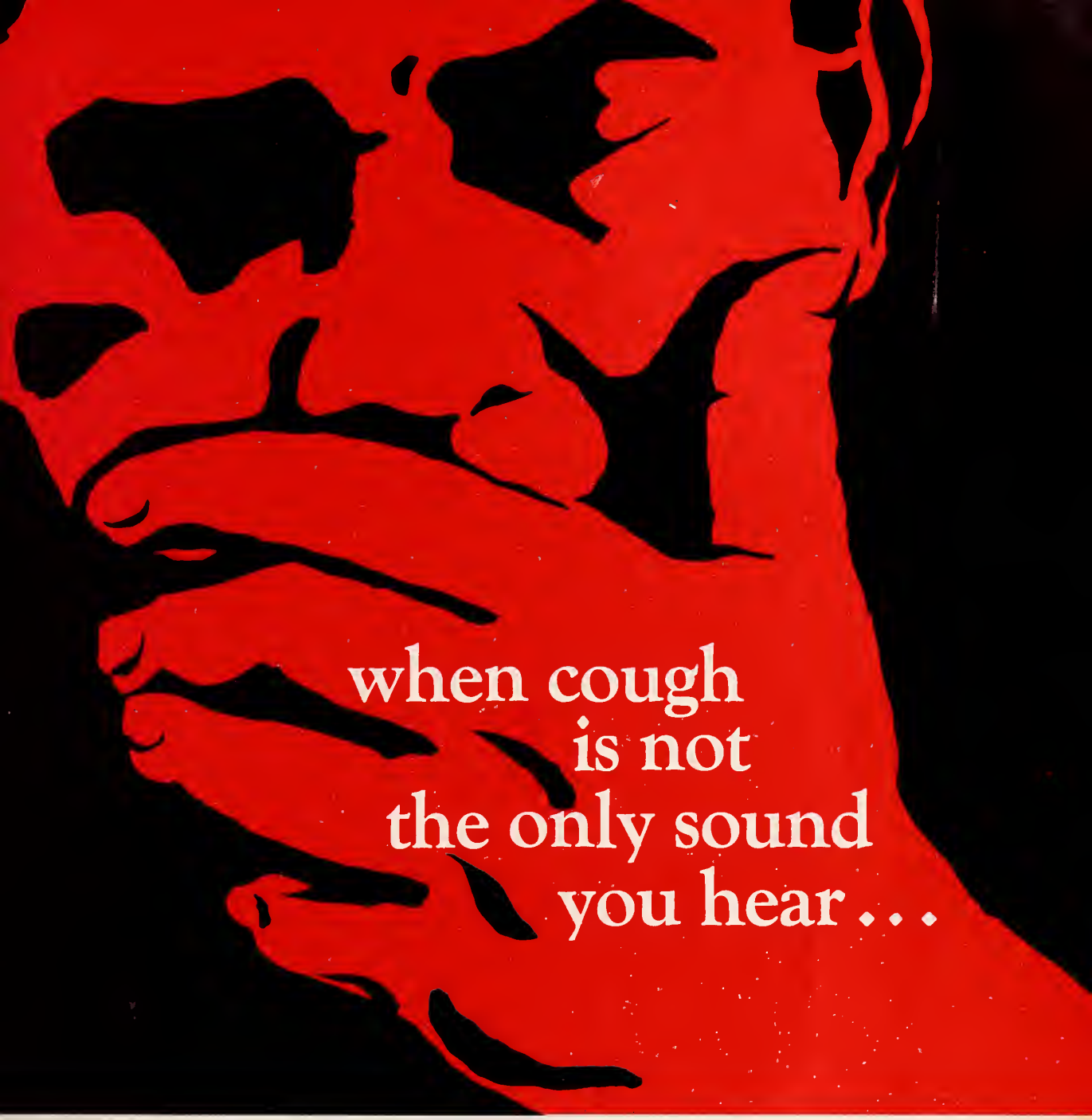
In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
*Paregoric (equivalent) ..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.
warning: may be habit forming
Pectin ..... (2½ grains) 162 mg.
Kaolin (specially purified) .... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three times daily.

ROERER

WILLIAM H. RORER, INC.
Fort Washington, Pa.



OMNI-TUSS® b.i.d.

. . . **because** OMNI-TUSS is indicated for cough associated with upper respiratory tract infections, bronchitis, bronchiectasis, bronchial asthma, emphysema, sinusitis and rhinitis, hay fever, or other allergic conditions. Any of these conditions may exhibit the general symptom syndrome—coughing, wheezing, bronchospasm, and tenacious mucus—which may benefit from the antitussive, bronchodilative, antihistaminic, and expectorant action of Omni-Tuss.

The therapeutic usefulness of Omni-Tuss is enhanced by a unique resin complex formulation providing the clinically desirable advantages of: (1) uniform drug availability throughout an extended period, (2) 8 to 12 hours of symptomatic control, (3) minimal dosage requirement, (4) minimal side effects.

Economical, efficient **b.i.d.** dosage—extremely well-tolerated by children, 6-12, and adults.

'Omni Tuss' Suspension: Each teaspoonful (5 cc.) contains 10 mg. codeine (Warning: May be habit-forming), 5 mg. phenyltoloxamine, 3 mg. chlorpheniramine, 25 mg. ephedrine, all as cation exchange resin complexes of sulfonated polystyrene, and 20 mg. guaiacol carbonate.

Available on prescription only. Class X exempt narcotic. Permissible on oral prescription.

Dosage: *Adults:* 1 teaspoonful (5 cc.) q12h.
Children (6-12 *years*): ½ teaspoonful q12h.

Side Effects: Minimal, but when encountered may include jitteriness, nausea, drying of mouth, insomnia, constipation, which disappear upon adjustment of the dose or discontinuance of treatment.

Precautions and Contraindications: For complete detailed information, refer to package insert or official brochure.

Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y.

is it depression?

She says "I can't sleep..."



...but her other symptoms:

anxiety, loss of interest, anorexia, psychomotor retardation strongly suggest an underlying depression.

---

when the diagnosis is depression

ELAVIL® HCl

AMITRIPTYLINE HCl

Indications: Mental depression and mild anxiety accompanying depression.

Contraindications: Glaucoma and predisposition to urinary retention. Not recommended in pregnancy.

Precautions and Side Effects: Drowsiness may occur within the first few days of therapy. Patients should be warned against driving a car or operating machinery or appliances requiring alert attention. When depression is accompanied by anxiety or agitation too severe to be controlled by ELAVIL HCl alone, a phenothiazine tranquilizer may be given concomitantly. Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having varying modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Monoamine oxidase inhibitor drugs may potentiate other drugs and such potentiation may even cause death; permit at least two weeks to elapse between administration of two agents; in such patients, initiate therapy with ELAVIL HCl cautiously with gradual increase in dosage required to obtain a satisfactory response. Caution patients about errors of judgment due to change in mood, and that the response to alcohol may be potentiated. May provoke mania or hypomania in manic-depressive patients.

Side effects include drowsiness; dizziness; nausea; excitement; hypotension; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of schizophrenia which may require phenothiazine tranquilizer therapy; epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration or, rarely, transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of the mouth, blurring of vision, urinary retention, constipation; paralytic ileus; jaundice; agranulocytosis.

Careful observation of all patients is recommended. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Supplied: Tablets ELAVIL HCl, containing 10 mg., 25 mg., and 50 mg. amitriptyline HCl, bottles of 100 and 1000; Injection ELAVIL HCl, in 10-cc. vials, containing per cc.: 10 mg. amitriptyline HCl, 44 mg. dextrose, 1.5 mg. methylparaben, and 0.2 mg. propylparaben.

Before prescribing or administering, read product circular with package or available on request.

MERCK SHARP & DOHME Division of Merck & Co. Inc. West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY



tones down the "explosive gut"

helps restore normal motility and tone

CANTIL®

(mepenzolate bromide)

Diarrhea and other symptoms of common G.I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

LAKESIDE

CONTRAINDICATIONS: Sensitivity to Cantil® (mepenzolate bromide), glaucoma, G.I. or G.U. obstruction, toxic megacolon. WARNINGS: Possibility of adverse reactions in advanced severe ulcerative colitis and atypical agitated reactions to phenobarbital in the elderly (Cantil with Phenobarbital). PRECAUTIONS: Cantil is of adjunctive use only; treatment of the underlying condition is indicated, be it organic or functional. Observe caution in conditions known to be incompatible with atropine-like drugs, e.g., open-angle glaucoma or prostatic hypertrophy. ADVERSE EFFECTS: Dry mouth; blurred vision; constipation; nausea; vomiting; bloating; dizziness; urinary retention. All are anticholinergic effects and usually tolerable. Habituation and idiosyncratic reactions to phenobarbital (Cantil with Phenobarbital) are possible, as is generalized rash. DOSAGE: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required. HOW SUPPLIED: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

Help the Needy!



A patient of advancing years may appear to "have everything," but may well be in need—*medically*. You know the symptoms. She's tired most of the time. Though there's nothing wrong with her organically, she suffers from general malaise. Lassitude has become her way of life . . . vague aches and pains her major concern.

Such a patient has entered the "Mediatric Age"—that stage of her life in which she's an ideal candidate for MEDIATRIC. This preparation provides the anabolic benefits of gonadal steroids, plus a gentle mood uplift and the nutritional support she's apt to need. MEDIATRIC is intended to help keep her more alert and active, and relieve general malaise . . . to help restore that sense of physical and emotional well-being that the elderly *deserve* to enjoy.

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens-equine), the orally active, natural estrogen so widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain anabolic balance to forestall premature degenerative changes related to estrogen deficiency. MEDIATRIC also supplies a small amount of *methamphetamine HCl* to provide a gentle mood uplift, and nutritional supplements specially selected to meet the needs of the aging.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.
WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.
SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.
SUGGESTED DOSAGES: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.
In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).
In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.
SUPPLIED: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.
No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.
No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.

	Each MEDIATRIC Tablet or Capsule contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC Liquid contains:
Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsiccated	30.0 mg.	—
Ascorbic acid	100.0 mg.	—
		(Contains 15% alcohol†) †Some Loss Unavoidable

Mediatric® tablets · capsules · liquid
Steroid-nutritional compound



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When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In bacterial/allergic u.r.i., ACHROCIDIN brings the treatment together in a single prescription —prompt relief of headache and congestion together with effective control of the tetracycline-sensitive organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

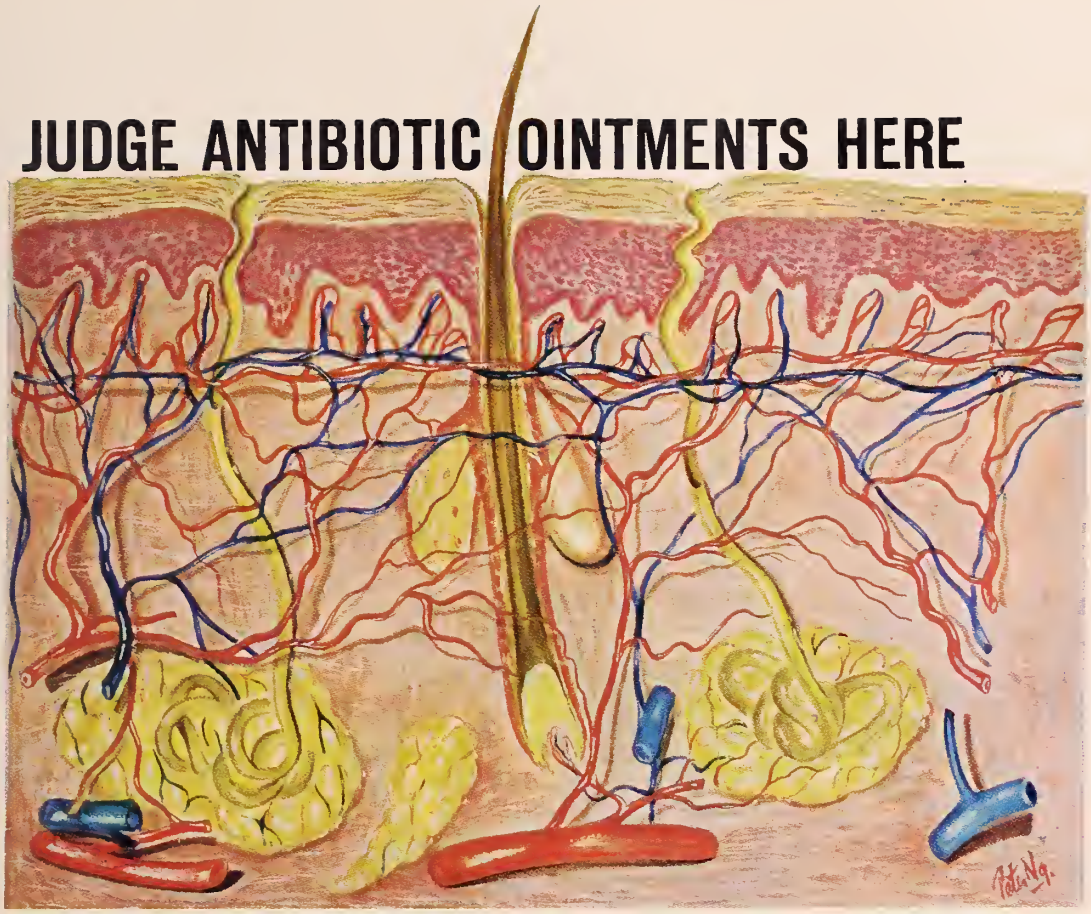
For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.
Contraindications: History of hypersensitivity to any component.
Warning: If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment, which should be discontinued at first evidence of skin discomfort.
Precautions: Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development may cause discoloration of teeth.
Adverse Reactions: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels following full therapeutic dosage has been reported. This has disappeared rapidly when drug was discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy and in children given the drug during the neonatal period, infancy, and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Lederle

350-8

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Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

New

Therapeutic breakthrough in non-narcotic control of the pain of

Tegretol®
carbamazepine

trigeminal neuralgia

Warning
Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.
Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.
Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.
Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.
Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.
In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.
Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.
Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.
Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.
Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.
Before initiating therapy, the following laboratory procedures should be performed:
1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.
2. Baseline evaluations of liver function.
During treatment with Tegretol, the following laboratory procedures should be performed:
1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent laboratory and clinical evaluations. Should this trend continue, the dr should be discontinued.
2. Liver function tests must be performed at regular intervals during tr ment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.
3. Periodic eye examinations, including slit-lamp, funduscopy and tono etry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.
4. Complete urinalysis and BUN should be done on patients treated w Tegretol because of observed renal dysfunction.
Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytos eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary fre quency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urin impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, eryth multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexi dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular eff are drug-related is not known. However, some of these complications h resulted in fatalities.) The necessity for discontinuing the drug should b dictated by the gravity and severity of the adverse reactions.
Dosage and Administration The drug should always be taken with meal if possible.
Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the do should be increased in one-half tablet (100 mg.) increments every 12 ho until freedom from pain is achieved. To relieve pain, between 200 mg. a 1200 mg. per 24 hours may be necessary.
Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.
At least once every 3 months during treatment period attempts should b made to discontinue the drug or to reduce the dose to the minimum effective level.
Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-A
For complete details, please see Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Geig

uncommon relief of uncommon pain




Grounds...for Regroton®
chlorthalidone 50 mg.
reserpine 0.25 mg.

when you want to provide the combined benefits of two accepted agents in the treatment of mild to moderate hypertension. (Contraindications: history of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.)

when you want to prescribe therapy that is generally well tolerated.

(However, adverse reactions may occur. For a complete listing, please refer to the full prescribing information which is summarized below.)

when your patient wants an easy-to-remember and reasonably priced regimen. (One tablet a day usually costs about a dime.)

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue 1 week before electroshock therapy, and if depression or peptic ulcer occurs. **Use in pregnancy:** Regroton should be used in pregnant patients or in women of childbearing potential only when, in the judgment of a physician, its use is deemed essential to the welfare of the patients; adverse reactions (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn. **Precautions:** Antihypertensive therapy with Regroton should always be initiated cautiously in post-sympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue Regroton therapy two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Regroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000. **For details, see complete Prescribing Information.** (B)46-600-B

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Regroton® **Geigy**

IMPORTANT FACTS

about

Professional Liability Coverage

Insurance that only covers claims based on the rendering of, or failure to render, professional services, or arising out of malpractice error or mistake in rendering professional services, is no longer adequate.

Our policy, approved and recommended by The Medical Society of New Jersey is broad enough to cover:

(1) the non-negligent as well as the negligent claim, such as arising out of duties as committee member in your society or hospital.

(2) The financial loss to a physician in attending trial as a defendant in protracted litigation.

(3) punitive damages for libel or slander.

This program, which was designed with The Medical Society of New Jersey and its legal counsel, and operated by a cooperative Loss Control Program, offers this broad protection, security and continuity of coverage.

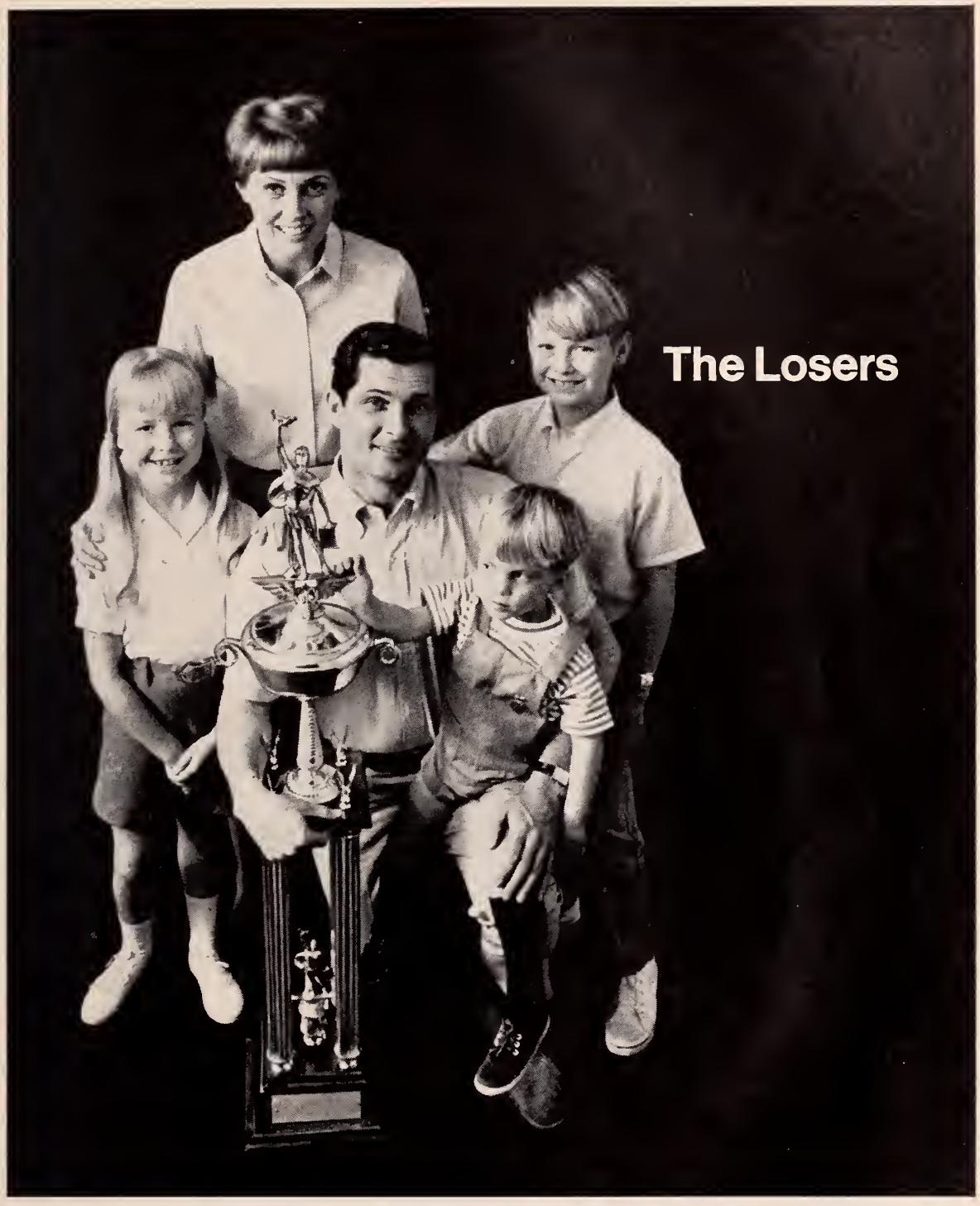
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They did it. They shaped up. They fought the losing battle and won.

And now they know what it takes to take it off.

They listened to a professional like you. Together they planned a losing strategy. Diet. Exercise. Rest. Will power. That's what made them physically fit. Not fad stuff or pot luck.

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Project Weight Watch can help, too. We have a complete portfolio of materials and suggested scientific diets available, free. The diets are a realistic balance of the 4 food groups—meat, breads and cereals, fruits and vegetables and dairy foods. Diets you'd write yourself if you had the time. Take a minute and send for them today.

PROJECT WEIGHT WATCH

FACTS, NOT FADS

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City

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Part of
the fine art
of medicine



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COMPOUND-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

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EDITORIALS

Our Dynamic Duo

John Kustrup



Eva Kustrup



Every year in this month's issue and in this space we have an editorial about our incoming President. This year, for the first time, the item will concern both the President and his wife. This is because, also for the first time, the head of our Woman's Auxiliary is the wife of the President of The Medical Society of New Jersey.

John Kustrup has long been an important and useful member of the civic and professional community of the Delaware Valley area. He received his M.D. at Georgetown in 1930 and came to his native city (Trenton) to intern at the St. Francis Hospital. At the end of his internship, he entered general practice. In 1939 he decided to concentrate on surgery and closed his offices to take graduate work in surgery at the University of Pennsylvania. This was followed by a surgical residency at the Wilmington (Delaware) Memorial Hospital. He advanced rapidly in his chosen specialty, soon became a Diplomate of the American Board of Surgery, a Fellow of the American College of Surgeons, a member of the distinguished New Jersey Society of Surgeons, and eventually director and chief of surgery at the very hospital where he interned. Dr. Kustrup holds surgical affiliations in consulting or courtesy capacities at many hospitals in the area. He has had experience teaching both anatomy and surgical pathology at the Jefferson Medical College. Dr. Kustrup has made several

significant contributions to the medical literature — one indeed was published in this JOURNAL.* His two sons, having honorably completed their military obligations, are physicians: one an ophthalmologist, and one a surgeon in Trenton.

Dr. Kustrup has been a good organization man. He served on our State Society's Board of Trustees and then began his ascent through the presidential chairs. He was President of the Mercer County Component Medica Society and later took charge of public relations for The Medical Society of New Jersey. He has served as President of the Mercer County Society of Catholic Physicians, and was a pioneer in developing the highly successful Medical Journal Club of Trenton. And, while his wife is a talented painter in oils, John Kustrup is a highly skilled photographer.

Mrs. Kustrup, the former Eva Hartig Williams, was born in our nation's capital where her father was the D.C. representative of Eastman Kodak. She took nurses' training at the Emergency Hospital in Washington, meeting John Kustrup who was then a medical student at Georgetown. After the doctor took his bride back to Trenton, Mrs. Kustrup became his office nurse, until this career was interrupted by the birth of Betty (now Mrs. Sheahan of Pelham Manor, New York) and twin sons, Jack and Bill.

Eva Kustrup joined the Woman's Auxiliary of the Mercer County Medical Society in 1932 and has worked on almost every committee of that organization. She was for six years co-editor of the Newsletter, now called *The Shingle,* the State publication for Auxiliary members. In 1964, a National Award of Honor was given by the National Safety Council to The Medical Society of New Jersey Auxiliary—and Eva Kustrup was that year Chairman of the Safety Program. She was President of the Mercer County Auxiliary in 1948, and since that time has been a member of the State Auxiliary Board.

Mrs. Kustrup served for several years as President of the St. Francis Hospital Aid (Trenton), and as Secretary to the New Jersey Association of Hospital Auxiliaries. She was founder of the Auxiliary to the Trenton State Hospital. An accomplished artist, she has painted murals on the walls of the new building of St. Francis Hospital. Two of her paintings won first prize in the state competition of the Federated Women's Clubs. She belongs to the American Artists' Professional League. And she sculpts, too. When asked what her hobby is, however, she answers: baby-sitting with her grandchildren.

* Kustrup, John F.: General Surgery In Psychotic Patients, *The Journal,* MSNJ. 44:9 (September, 1947) P. 357.

J. Howard Hornberger 1896-1968

The death of our Past-President, Jennings Howard Hornberger, symbolizes the passing of an epoch: the era of the general practitioner with wide-ranging civic interests, a sense of community duty, and the affectionate virtues of the traditional family doctor. He earned his M.D. degree in 1921 at the University of Pennsylvania, one of the Ivy League medical schools of our nation. He loved people, and because he did, he fitted beautifully into the small town neighborly culture of southern New Jersey. In addition to a growing family practice, he was associated with John A. Roebling's Sons Company, eventually becoming medical director there. He loved children and served the Board of Education of Florence, New Jersey, soon becoming senior medical examiner for the schools. With the passage of selective service legislation in 1939, he became a medical examiner for the draft board, eventually being designated chief physician to the draft board in Bordentown. The Chosen Freeholders of Burlington selected Dr. Hornberger for a seat on the Board of Managers of the Burlington County Tuberculosis Sanatorium. He was affiliated with most of the

general hospitals in the county, and, so far as our profession was concerned, he was one of South Jersey's most distinguished citizens. He did all this with a kind of continental grace, an interesting mixture of charm and sophistication. It somehow seemed appropriate for him to be raising pheasants. His medical colleagues had twice made him president of his county society. He served on the Board of Trustees of The Medical Society of New Jersey for sixteen years. He was installed as head man of our state society in 1948. He was a doctor's doctor, an organization man in the best sense of that phrase, and a tower of strength, wisdom, and good will in his own community.

The Decline Of Privacy

Once it was all so simple. You went to a doctor in whom you had confidence. You closed the door and spoke privately. Your conversation was as sacred and protected as words said in the ear of a priest in a confessional booth.

But now, 30 per cent of all medical bills are paid by third parties — Health Insurance, Blue Shield, Social Security, Retirement Benefits, Labor Union Plans, Medicaid, the Veterans Administration, and so on and on. Well, you can't blame the paymaster for asking what he's paying for. So the diagnosis has to go into the files of an insurance company, a government agency, or an employer. And though it may be stamped "confidential" that is likely to do no more than whet the curiosity of the clerk, adjuster, attorney, messenger, or claim investigator in the office which receives the report.

Then come the data processing experts. They convert your diagnosis into holes in a punch card. This spews forth a "print-out" converting the holes into numbers or words on a tape.

We live in a fearfully complex environment where every one's safety may depend on some one else's health. You want to know if the driver of your kid's school bus has epilepsy. Fair enough? But the Board of Education won't know it unless some doctor tells them. Is the pilot of your jet plane free of coronary attacks? Does the driver of a fast moving passenger locomotive have vision keen enough to distinguish a rising moon from a yellow signal light?

What of the patient in your office? You say that you are discrete. You insist that when it comes to telling about one of your patients, mum's the word. Well, is it? The police are entitled to know if you treated a gun shot wound or a narcotic addict. The AMA gives you a conscionable way out. Canon No. 9 reads: "A physician may not reveal confidences entrusted to him . . . unless he is required to do so by law, or unless it becomes necessary to protect the welfare of the community." That last exemption leaves in the tissue of confidentiality a hole big enough to drive an Imperial through. What's necessary to protect the welfare of the community? Finding a contagious disease? A bullet wound? A homicidal maniac? An epileptic bus driver? Your patient's fiance's syphilis? A paranoiac who plans to plant a bomb? A man with sadistically deviated libidinous drives who has been named as a foster parent by a trusting social agency? Or a pyromaniac loose in a sleeping city?

Anyway, every American-born adult has a health record and a psychologic record in the files of the school system, the armed services, and any health insurance companies to whom he has ever applied for coverage. That doesn't leave many Americans with blank files, does it?

And waiting in the wings is a proposed national data bank. Here will be permanently stored the minutiae of everybody's medical life — details which can be swiftly dug out by modern retrieval and computing methods. And just around the corner is a brand new electronic eavesdropping device!

Privacy — that's a seven-letter word you can still find in the dictionary. But soon, you'll have to go to the dictionary to find it.

ORIGINAL ARTICLES

Here is the installation address of our new president, a call to rededication.

Our Great Task Today*

John F. Kustrup, M.D./Trenton

Mr. President, President-Elect Wilbur, Officers, Delegates, and Members of The Medical Society of New Jersey, Distinguished Guests, Ladies and Gentlemen:

To be elected President of a state medical society is a singular honor and a great responsibility. To be elected President of The Medical Society of New Jersey, the oldest medical society in the United States, is an honor of surpassing distinction.

My knowledge of your stature as physicians and members of the profession fills me with humility, pride, and gratitude for having been chosen by you for this position. I shall strive at all times to be worthy of your trust. In this 202nd year of this Society's existence, our thinking must be directed not only toward programs that affect physicians and their patients but also toward programs that affect us all as citizens.

I recall an incident of my early childhood — the time, a few days before Christmas. I wanted a pair of roller skates, and I was told by my mother that I could not have them because we couldn't afford them. I pointed out that other boys got toys by simply going to City Hall and asking for them. To this my mother replied, "That is for poor children. As long as your father is working we have only what we can afford." She then added, "This is a great country. You can get anything you want if you are willing to work hard enough for it. Don't think of what your country can do for you; think of what you can do for your country." (Thus my mother anticipated our late President Kennedy by almost a half century.) Her observation, it seems to me, merits frequent repetition.

To make and keep this country strong and united, proud and free demands an individual philosophy of personal responsibility. With this as a key we open the doors to self-respect and dignity, both of which qualities can be obtained only through individual initiative. A well-earned respect for one's self, embodying, as it must, a perception of one's rights and duties, inevitably leads to respect for the rights of others.

Because the rights of others have not dependably and fairly been respected, tensions have been generated and animosities and violence evoked. Government has therefore stepped in, with the object of righting wrongs and re-establishing orderly social relationships. This intervention has led to more laws, more taxes, and more curtailment of individual freedom, unhappily without consistent improvement in the salutary social adjustments sought.

In a society such as ours, many problems arise which can be solved only with the assistance of government. One of the most widely discussed problems of this day, other than the war in Vietnam, is the problem of our "economically disadvantaged" citizens. Society cannot ignore the poverty-stricken, no matter what the reasons for their poverty. All of us know that a certain proportion of our popu-

* Delivered to the General Session, The Medical Society of New Jersey, May 19, 1968, Atlantic City.

lation seems to be made up of people who are constitutionally ill-equipped to make their own way and to provide for their own needs. Others are the victims of adverse fortune. These people must all be helped. The obvious means are two: governmental programs and the charity of private citizens. Among the poor there are those who are mentally and physically able and willing to work. These people must be trained for jobs, given opportunities for education, taught the meaning and satisfaction of personal effort and individual responsibility as the only means to personal freedom through accomplishment, and encouraged to develop dignity and self-respect.

What is our role as physicians? Physicians have long recognized their responsibility in the care for the poor. Through the years physicians have spent countless hours caring for the poor — through house calls and office visits and professional services of all kinds rendered in clinics, hospital wards, emergency rooms, and operating rooms — all supplied without consideration of financial return.

One governmental plan to care for the poor in urban areas is by establishment of medical health centers under the auspices of the Office of Economic Opportunity. These proposed health centers should involve original solutions adjusted to local conditions. No new facilities should be built where already existing facilities are adequate. Social service organizations operating from a central unit should seek out those who need medical attention and should be in a position to furnish means of transportation to and from the sites where care is to be rendered. This care should be available in private physicians' offices, in hospitals, or in clinics of the patients' choice. All services, accommodations, and care rendered to these patients under governmental auspices should be at the same level of quality and on the same terms as are those rendered to self-paying patients.

The OEO must be reminded that medical manpower, both in the number of licensed physicians and the number of personnel in associated health fields will still remain constant in communities where its programs are being set up. The establishment of a program to pay for care does not automatically increase the number of qualified persons capable of rendering such care. Efficient planning will necessarily make the best use of existing available facilities and personnel.

Original governmental estimates of the cost of services to be met under Title 18 (Medicare) fell far short of the actual experience. In part, this was because the Government had not recognized or appreciated the volume of services contributed gratis by the medical profession, for which services now, under Medicare, government is committed to pay. A second factor productive of the disparity between estimated and actual costs was the fact that no distinction was made under the program between eligibility for *necessary* medical care and eligibility for merely *desired* medical care.

As regards the rendering of free medical and surgical care, the policy of organized medicine has long been summed up in the dictum, "No one shall be denied necessary medical care because of inability to pay." The word "necessary" is imperative here to protect the physician from imposition at the hands of thoughtless patients who would level on his time and skills for whatever ills or aliments they fancied they had. The physician treated without charge only when the state of the patient's health indicated need for such treatment and the state of the patient's finances may manifest his inability to pay.

Government has thus far set no such salutary limitations on services whose cost it will underwrite. Consequently, under governmental programs costs have ballooned beyond the naive expectations reflected in the early official estimates.

The physician of today does not work alone. Individuals working with the practitioners of medicine must be recognized as co-workers. The ratio of physicians to the rest of the

health team is 1 to 13 and is rapidly changing. These associates of ours have a status to maintain, and we can assure that status by giving them deserved recognition and appreciation.

In 1967, the total of physicians graduated from medical schools in the United States was 7,743. This falls far short of our needs. Existing medical schools must be encouraged to add at least 25 per cent more to their student enrollment. This quantitative improvement, authorities agree, can be accomplished without a sacrifice of quality. Nationwide, the need for more medical schools is obvious.

The two medical schools already established in our state (as The Medical Society of New Jersey has consistently urged) must be expanded. Their students, in the public interest, must be encouraged to recognize the great need within our State for more family physicians. Plans must also be evolved, we feel, for a third medical school, in the southern portion of New Jersey.

Community hospitals should be included in the overall planning for our medical schools, so that attending physicians in community hospitals may have more and better access to continuing education, and so that community hospitals may have firm relationships with the teaching institutions and their related facilities and personnel.

Medical graduates of these schools of ours should be encouraged and advised to intern in our approved community hospitals. For the current year, New Jersey's hospitals approved for internships have obtained only 57 interns out of a total of 600 applied for under the National Intern Matching Plan. This figure represents an all-time low. It must be corrected. A conference of the physicians in this State interested in this program should be convened to determine and evaluate the best solution for this vital problem.

As regards implementations of Title 19 (Medicaid) in New Jersey, we of The Medical Society of New Jersey have pledged ourselves to cooperate in every constructive way with State authorities. We will work for a program in the best interest of all needy patients. Our program for Medicaid — as regards standards and terms — is identical with that already mentioned in conjunction with Medicare. Beneficiaries should have equal advantages and status with all other patients. Compensation for such services should be on the same basis as that applying to patients paying their own way.

Implementation of the Regional Medical Program for heart disease, cancer, and stroke is progressing. Fundamentally this program is being planned for the continuing education of physicians, the specialized education of nursing personnel for coronary and intensive care units, and the education of the public to stimulate early diagnosis and prevention of heart disease, cancer, and stroke.

The Society has been, and is, working assiduously to improve and make more efficient the rendering of emergency care, especially in disaster situations, throughout the State. Particular emphasis is placed upon constant upgrading of methods of first-aid and emergency care, the use of well-staffed and properly equipped transport vehicles, the adoption of a two-way communication system to insure prompt and efficient care for the injured in receiving centers, and, finally, the delivery of high quality medical care by expert personnel in the emergency rooms of all hospitals.

I want to say a word of appreciation to those members of our Society who serve on its councils and many committees. It is through them that the Society evolves and builds its programs, and through them that it pursues its constructive goals. We are deeply indebted to those members who give of themselves in service to the Society and to the public. I offer a word of invitation to interested members who are willing to make a like sacrificial contribution to identify themselves with the activities of both The Medical Society of New Jersey and its component societies. There is much work to be done and always room for more willing and able workers.

Our Bylaws state that no member of any administrative council or standing committee, except the Council on Legislation, shall serve for more than three consecutive three-year terms. A number of very active and valuable members have this year become ineligible for further services because of this stipulation. In appreciation of the work they have done loyally and unselfishly, I extend my sincere thanks on behalf of the entire Society.

A prime group to whom tribute must also be paid is the Woman's Auxiliary to The Medical Society of New Jersey. Members of the Auxiliary have been most helpful in promoting better public relations, in spearheading health career activities, in advancing the health education of the public, and in numerous other areas and aspects of health services. Every male member of The Medical Society of New Jersey should encourage his wife to become a member of our Woman's Auxiliary.

The rapidly changing political scene and the many socialistic practices that are being thrust upon us necessitate greater individual civic responsibility. This responsibility means increased exercise of leadership in surveying health facilities and related potential needs in our communities, and in bringing about the proper satisfaction of those needs.

Increased civic responsibility also means active participation in the area of politics. A ready means for such participation exists for us in JEMPAC. I strongly urge all our members to join with our fellow physicians as members of the New Jersey Medical-Political Action Committee.

These are times to test the mettle of men. Even under ordinary conditions, life is challenging for every man. With the extraordinary circumstances of these days, the difficulties with which life confronts us are sufficient to discourage the ardors of all but the most clear-thinking and stout-hearted. Changing social philosophies and aggressive individual attitudes are modifying radically all the constants of principle and of conduct upon which we were once able confidently to rely. Life has become almost literally a warfare — for nations and for individuals. If we are to emerge from the deepening crises that assail us with personal liberties and securities preserved, with human dignities unimpaired, with incentives and aspirations undestroyed, we must fight for the ideals and purposes that have long inspired and sustained us as individual American citizens and as a nation.

In these most significant and vital times it is for us of the profession of medicine to rededicate ourselves to our ideals as persons and as physicians, to re-apply ourselves with increased devotion and energy to the preservation of the best in medicine and in American life, to do the job in the public interest that is ours to do. To fail in these times is to fail for all times. . . . With firm purpose and high hearts, let us go forward now to work at our great task together!

1418 South Broad Street

Ethical Telephone Listing

Is it ethical for a physician to list his specialty in the telephone directory? And to what extent?

A six-page booklet, "Guidelines for Telephone Directory Listings," readily answers such questions. This booklet is useful to the county medical society, the physician, and the local telephone company in assisting the public while maintaing the dignity of the medical profession. The booklet, prepared by the Judicial Council, may be obtained from the AMA's Department of Medical Ethics at no charge.

No general practitioner, and no consultant, regardless of specialty, can avoid seeing patients who are plagued by depression. Here is a consideration of melancholy, correlated with the patient's sex.

Depression And Gender

Karolina Bein, M.D./Newark

Every one agrees that the patient should be treated as a "total person" rather than as a specimen who is either totally sick or totally healthy. The physician may say there is nothing wrong with you, that it is all in your mind, or that "it is all nerves." But the mind, after all, is in the body and is part of the body. The mind, indeed, is the executive of the body — it makes you do things or not do things. When one hand is broken a person can use the other, can walk, communicate, use all of himself except for this one incapacitated part of his body. When the mind is sick, say in catatonic stupor, nothing works. In depression there is always inhibition which may reach the point of cessation of activities.

Each doctor, in the ordinary course of his practice, is faced with the possibility of depression in his patients. Initially, the complaints are physical rather than emotional. Thus, depression may, in its beginning stages, simulate physical illness. Disorders of thought or breaks with reality are not as evident as physiologic complaints. Usually, thought processes are not affected except in far advanced cases. Physically, the presenting symptoms of depression may include any or all of these seven symptoms:

(1) Changes in body posture and facial expression (stooped down, dejected facial expression)

(2) Loss of, or increase in, appetite

(3) Motor inhibitions

(4) Fatigue

(5) Sexual complaints

(6) Vaso-vegetative disturbance

(7) Sleep disturbances-insomnia or "sleeping all the time"

The patient often consults the doctor with fatigue or insomnia. Those are the "night people" who can't get up early in the morning and who can't fall asleep at night. Often there is a disturbance in eating habits, lack of interest in food or an excessive food intake with resulting obesity. Frequently, an increase in the intake of alcohol is observed. The patient suffering from depression will usually recite a variety of aches and pains. These are non-specific, generalized, and not pathognomonic of any particular organic syndrome. Sometimes the initial complaint refers to sexual problems, frigidity or impotence. Anticipatory fears concerning fatal diseases may be expressed. These include cancerophobia, brain tumor, heart ailments, or terminal illnesses. Less often the presenting complaints are expressions of dissatisfaction with one's self: an exaggerated self-criticism as it were. Presenting complaints may vary according to sex. Women express concern about "getting old," being unattractive, too fat, or too skinny. Men, on the other hand, complain about a loss of strength, an inability to work, or reduction in general productivity and alertness.

Depressed people are often "hypomanic." This is best defined as an attitude of inappropriate "forced gaiety." They may constantly joke, talk rapidly (push of speech), and appear to be very active. They try to make enough noise to silence their innermost menacing thoughts. They may betray themselves by a sad or angry "look" in their eyes and by their inability to "let go" of the joviality which is so often inappropriate to the situation in which they are involved.

It is easier for the patient to complain about a lack of sleep, aches, pains, or a "bad stomach" rather than a "bad lot in life."

The patient who may appear in the office during an examination to be only "slightly tired" may actually be spending many sleepless nights with gloomy and suicidal thoughts. It is not rare to read about an individual who is described as "not depressed" but who was found dead as a result of suicide. Considering the tragic consequences that can result from depression the question to be answered is: "Can the points of origin of emotional conflict leading to later mental breakdowns be recognized and their effects immunized?" (Ewalt[1])

In 1917, a classical paper on depression entitled, *Mourning and Melancholia* was written by Sigmund Freud.[2] In it, Freud wrote, "Mourning is regularly the reaction to the loss of a loved person, or the loss of some abstraction which has taken the place of one, such as fatherland, liberty, an ideal, and so on. As an effect of the same influence, melancholia instead of a grief develops in some people, whom we consequently suspect of a morbid pathological disposition."

This loss of some abstraction ("which in a situation of great value may often involve loss of self-esteem") may vary considerably relative to men and women because of a basic difference in their physiological and emotional structures. Depression is an emotional response to a loss; but the lost object or its symbolic representation must be of exceptional value to the individual. For men and women, some objects and symbols have more meaning than others.

The physiologic role of women is more complicated than in men. Their bodies perform a variety of functions distinct from those of the male. All women are not emotionally ready to accept the mystique of their bodies. They are often resentful of their normal functions. This resentment may be conscious or unconscious but it results in different neurotic manifestations which a doctor can observe, e.g., the remarkable behavioral changes involving menstrual flow, pregnancy, or menopause.

A woman may be concerned about losing her appeal, her attractiveness, and loveliness. These assets are important to a female who biologically has to "attract" in a passive way. This is universally represented in all mammals in coital situations where the female passively attracts while the male actively performs. The mental abstraction of the role woman plays in the vital reproductive act is expressed through a need "to be loved" (to attract), while for the man it is perceived as having the power and strength (to perform). Consequently, any infringement on a woman's sense of being able to attract or to be loved, or a man's ability to perform or to be powerful will be disguised as a feeling of "loss" and therefore depression. In women, emotional manifestations are provoked by physiologic changes. In men, socio-cultural factors assume a greater importance in the determination of behavioral reactions.

The physiologic and emotionally-charged changes in women are well known to all physicians. The menopause is equated with being old, unattractive, and unappealing. Many "menopausal symptoms," such as involutional depression can be explained on the basis of a woman's emotional reactions to "growing old." This would also appear to be a valid explanation for the reactions that occur after hysterectomies. In the author's experience (based on clinical observations) it would seem that young, attractive women tolerate hysterectomy better than older, less attractive women approaching the menopausal age.

Another factor is the tendency to "mood swings" preceding menstruation. Women who consider the menstrual flow as "dirty" or refer to it as the "curse" feel that during the period of menstrual flow they are repulsive, dirty, and unattractive. Natalie Shainess[3] tells us that menstrual symptoms can be divided into the physiologic and the ancillary. The ancillary symptoms are best understood in loss of self-esteem and ego defense. Fox[4] says that at

age eleven, "she had her first menstrual period. She felt drawn to her mother and told her about it, but experienced a painful rejection when her mother remarked that this is not the sort of thing that people discuss." Fox[4] suggests that ancillary menstrual symptoms suggest psychologic damage.

How about the "post-partum depression" or "blues" experienced by women? This is most likely to occur in women who have over-invested emotionally during the pregnancy experience. These are often the women who assert they "never felt better in my life" or who boast: "I love to be pregnant." They thrived on the attention that they received during pregnancy and were proud of the increased size of their body. For these women, the parietal experience is felt as a loss of the desired gestation.

Concerning men, the "everyday situations" causing depression are harder to detect. In our culture, males are reared in a tradition where the overt expression of emotion is perceived as a nonmasculine trait. Therefore, they are reluctant to complain. Men often keep feelings to themselves, and attempt to control their emotions in their own way. This may be why suicide and alcoholism rates are three to four times higher in men than in women. Unlike women, men cannot utilize physiologic reasons as an excuse for problems over which they have no control. Men feel directly responsible for all their problems. They experience shame in revealing them. In such a situation, it requires perception and sensitivity on the part of the doctor to appear interested and supportive, rather than theatening. The image of "maleness" is equated with success and aggression in our competitive society. It is not easy to maintain, and the frustrations and tensions are numerous. Thus, each time there is a situation that calls for a reaffirmation of the "masculine image" there is an anticipatory anxiety or resulting depression. Here is a clinical illustration of these factors:

1. A married woman complained that her husband had become impotent. Her husband was reluctant to consult a physician. Finally, he consented to see an internist who prescribed Vitamin B-12. No improvement was noted. Six weeks ago her husband resumed normal sexual activities and my patient, who had gained considerable insight as a result of her own treatment, gave this explanation:

Her husband, a stock broker, was a hard-working man and a good provider. He derived a great deal of satisfaction from his earning abilities. When the stock market went down, he lost money for himself and his clients. The sudden change in fortune for this young and not yet experienced businessman caused a depression. Thus, he experienced chronic fatigue and the loss of sexual interest so common in depression. However, when the stock market became more stable and he regained new clients, his depression vanished. I agreed with my patient's evaluation of the situation and realized that her interest in the Dow Average was motivated by more than just financial reasons.

If it is easy to understand a depressive reaction to the loss of money or position. A man may also react with a severe depression to "success" of a "gainful situation." The situations that may precipitate depression may include graduation, service in the armed forces, marriage, fatherhood, or even a business promotion.

Why should men develop severe depression when they learn that they have been promoted? It means leaving the old and the familiar, the comfortable situation wherein they have achieved well, proved their abilities and skills. Now they must go into a new situation where the necessity for proving oneself all over again is anticipated. An example of this situation is as follows:

2. A male patient was referred to me with a severe anxiety which totally incapacitated his functioning. It turned out that the anxiety was caused by a fear of suicidal impulses. This was a 40-year-old married professional man, the father of five children. For the last two years he found himself drinking more and enjoying life less. He worked hard, attended graduate courses at night, and was about to receive an advanced college degree. Suddenly, he experienced severe attacks of anxiety which he could conceal from his colleagues only with extreme difficulty. At home he was unhappy, cried, could not sleep, and seriously considered "finishing all his problems by killing himself."

Several months prior to the onset of his depression, he had achieved a position of importance that placed him in considerable authority. From that time on he was tormented with doubts about his ability to cope with the new situation. He wondered if he could succeed as well with the new task as he had done with his last position. He felt like a little boy assigned to do a man's job. He was afraid his inadequacies would be discovered and that he would lose other people's respect and confidence. Symptomatically, he had always had a history of mild chronic depression. After a brief exposure to psychotherapy he was able to resume a full life and succeeded in his new position.

The extent of depression increases with age and it is a very common phenomenon in people over 60 years, especially if they live alone. Here again, men are in a more difficult position. A retired man usually has "nothing to do." He can't occupy himself at housework, he has difficulty socializing. His attachment to "sons" never resembles the woman's closeness to her "daughters." It is not unusual to find that older men like to drink, or withdraw into the loneliness of a boarding house. Some commit suicide and others die shortly after their retirement.

In contrast, a woman's activity in old age still revolves around the care of a house. She makes friends more easily than men. Women seem able to maintain longer lasting friendships. If she has children, her life still continues to be involved with their problems. A woman's "old age" is far less lonely than a man's.

Medicine and psychiatry have undergone revolutionary changes from the time when depression, as described by Hippocrates, was attributed to "black bile." An explanation of the depressive disorder according to sex might be of value to the doctor in an early recognition of the problem.

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455 Elizabeth Avenue

M.D.—Head Start Consultation

A new partnership between Project Head Start and the pediatricians of America has been announced by the Office of Economic Opportunity and the American Academy of Pediatrics. Sargent Shriver, director of OEO, and William S. Anderson, M.D., president of the AAP, said that the Academy will organize and direct the Medical Consultation Program of Head Start child development programs in 2,000 communities.

The Academy has chosen Robert S. Mendelsohn, M.D., a pediatrician from Chicago, to direct the program. Mr. Shriver welcomed the wholehearted support offered to the program by the Academy, which represents more than 10,000 pediatricians in the U.S.A., and Canada. This program is hailed as a new type of relationship between an agency of the Federal Government and a voluntary professional organization. In effect, the American Academy of Pediatrics has accepted a major responsibility for ensuring that the health services provided to Head Start children adequately meet the health needs of these children, their families, and the community in which they live.

Initially, the AAP will select 300 physician consultants to evaluate the medical aspects of the Head Start program at the local level. As more physicians gain experience in community health programs, their increased skills and knowledge will make their advice more valuable in planning and carrying out programs which require partnership between physicians and government. Each physician will review the medical aspects of Head Start applications submitted by a community; meet with local planning committees to map out Head Start medical programs; maintain contact with program medical directors; follow up and evaluate programs; and maintain liaison with OEO regional and national offices.

With rare exceptions — here spelled out — Dr. Perkel believes that medical treatment will be effective in 90 per cent of peptic ulcers.

Medical Treatment Of Peptic Ulcer*

Louis L. Perkel, M.D./Jersey City

New drugs for the treatment of ulcer are being frequently introduced. Their evaluation is difficult because of the tendency for uncomplicated peptic ulcers to heal — even without treatment. Unpredictable and spontaneous remissions (part of the natural history of peptic ulcer) could easily attribute undeserved credit to any drug or treatment that happened to be given at the time. Such treatment may, in fact, amount to nothing more than a placebo. Furthermore, the practitioner is bombarded with enticing and optimistic propaganda which alleges that this product or that, be it an antacid, an anticholinergic or some combination, is the most efficacious and has the fewest side effects. Abetting this propaganda are the occasional uncontrolled case reports published by some physicians.

Peptic ulcer is the end result of an abnormal physiology, characterized by the inability of localized areas of the stomach and the duodenum to resist the digestive action of gastric juice. Its importance is attested by its high incidence — about 10 per cent of the adult population — and its considerable morbidity and the significant mortality resulting from its complications.

Suggested causes may be grouped into five categories: (1) constitutional or hereditary; (2) psychosomatic; (3) defensive or tissue resistance; (4) aggressive or acid-pepsin erosive action; and (5) a miscellaneous group.

Constitutional or hereditary influence is suggested by its frequent occurrence in families. Duodenal ulcer patients and their immediate families have an excess "appetite juice" which is believed to be evidence of an inherited hypersecretory pattern and an increased parietal cell mass. It has also been found that patients with blood group O and who are non-secretors of ABH substances, are 40 per cent more likely to develop peptic ulcer than are those with groups A, B and AB, further suggesting an inherited predisposition to ulcer. It was once thought that the lean, lanky body build was a factor, but this habitus is not now considered as characteristic.

Peptic ulcer is considered by many to be a *psychosomatic* disease. There is some evidence implicating emotional factors in its etiology. Certain brain lesions have been associated with upper gastrointestinal ulcerations. *Stress* may produce functional changes that predispose to ulcer. There may occur increased acid secretion, mucosal engorgement and friability, as demonstrated by Wolf and Wolff[1] in their fistulous subject "Tom." And stress, either physical or emotional, induces the hypothalamus to secrete a hormone which stimulates the pituitary secretion of ACTH. This, in turn, causes the adrenals to release cortisone which stimulates the gastric glands to secrete more acid and pepsin. This is why ACTH and cortisone are contraindicated for the ulcer patient, except when urgently required for an associated condition.

* Read November 29, 1967 at Bergen Pines County Hospital as part of a symposium on "Current Concepts In Gastroenterology." Dr. Perkel is director of Graduate Education in Gastroenterology at Bergen Pines County Hospital, Paramus, New Jersey.

Peptic ulcer is more common in city people and among physicians and executives, suggesting the influence of stress. Indeed, an ulcer is almost considered the prerogative of the high pressure, dynamic, aggressive executive. Most ulcer patients are characteristically tense, restless, and overly ambitious. Many of those who appear calm outwardly may be seething inwardly. Psychoanalysts have described specific emotional conflicts in ulcer patients, but peptic ulcer is relatively uncommon among frank psychotics. While there may be some doubt as to the role of emotional factors in the actual production of an ulcer, abundant evidence (both experimental and clinical) indicates that episodes of emotional stress, such as sustained anxiety, hostility, or frustration, are associated with exacerbations of ulcer.

Many theories have been advanced to explain the *lowering of tissue resistance* — the defensive factor. Foremost is the loss or impairment of the protective barrier, mucus, permitting the erosive action of acid-pepsin. Another theory, first suggested by Virchow,[2] is that ulcers are caused by impairment of the local mucosal blood flow due to vascular occlusion of the small nutrient blood vessels. Other factors believed to play a role in resisting ulceration are the alkalinity of the blood in the mucosal capillaries and the remarkable regenerative capacity of the mucosal epithelium cells.

The ability to *increase tissue resistance* is very limited by known methods of therapy other than the maintenance of good health and nutrition and protection of the gastric mucosa from irritants. These include foods that are mechanically, chemically or thermally irritant: alcohol, tobacco, caffein, salicylates, and other drugs.

The *acid-pepsin erosive component* is conceded to be a most important factor. It is not the sole cause, as hyperacidity is a frequent finding in non-ulcer patients. However, peptic ulcer occurs only in the presence of hydrochloric acid and pepsin, as in the lower end of the esophagus; the stomach; the duodenum; the jejunum, after gastric surgery; and Meckel's diverticulum, due to the presence of ectopic gastric tissue. Acid-pepsin erosive action is controlled by neutralization of the acid and by prevention of acid secretion. The former is accomplished by antacids as well as by small frequent feedings of bland foods which combine with acid and also diminish hunger contractions. In marked hypersecretion, particularly when associated with delayed gastric emptying, continuous gastric drainage by suction is another method of controlling the acid-pepsin factor — by removing it. Actually, it is more important to prevent acid secretion, than to neutralize it. This is accomplished by three major methods: (1) avoidance of acid stimulants, such as large meals, meat extractives, bulky or irritating foods, coffee, alcohol, tobacco and ulcerogenic drugs, as steroids, salicylates, rauwolfia, butazolidine, indocin, etc.; (2) depression of vagus activity, to diminish the cephalic phase of acid secretion, by use of sedatives, tranquillizers, anticholinergics; and through psychotherapy; (3) by ingestion of fats, which on entering the duodenum, cause an elaboration of the hormone enterogastrone, which inhibits gastric secretion.

Among the miscellaneous group of proposed etiologic factors are parathyroid and pancreatic tumors, pituitary, adrenal and sex hormones, allergy and focal infection.

Treatment

Objectives in the treatment of peptic ulcer are relief of pain, the complete healing of the ulcer, and prevention of recurrences and complications. We are most successful in accomplishing the first. Relief of pain, which can occur after a few days of rest and simple dietary regulation — or even spontaneously — by no means signifies the healing of the ulcer. Average time required for healing is from 6 to 8 weeks. This period must be taken into account in planning the treatment schedule.

The treatment of peptic ulcer is primarily medical, which, in about 90 per cent of in-

stances, is reasonably satisfactory. The remaining 10 per cent may require surgery either for the complications not amenable to medical measures or for so-called intractability.

Medical treatment cannot actually heal an ulcer. Nature heals the ulcer. Our goal is to create the best conditions for the natural healing process by trying to control the known aggressive factors; and to increase the defensive factors.

The management of peptic ulcer will be discussed under the following seven headings: 1) treatment of the patient as a whole; (2) rest; (3) diet; (4) medication; (5) radiation therapy; (6) the gastric ulcer problem; and (7) indications for surgery.

Treat the whole patient, not just the local lesion. The term "peptic ulcer" would be better replaced by "ulcer disease" to emphasize the involvement of the whole person. In this disease, particularly, the psyche requires as much attention as the soma. In no other condition is the art of medicine so important. Emotional stress often accentuates the aggressive factors. This may prolong chronicity as well as bring on a complication or a recurrence during a remission.

Formal psychiatric treatment is not required except when indicated by an associated unrelated emotional disturbance. Excellent results are attainable by informal, or superficial psychotherapy by the personal physician. This starts with a good patient-physician rapport, the foundation of successful treatment. A complete unhurried examination with sympathetic interest instills confidence in the patient. Any method of treatment, no matter how strictly carried out, may be ineffective if the patient has no confidence in the physician who prescribes it.

Listening attentively to the patient's discussion of his problems is of help in providing the opportunity for ventilation and assuring the patient of his physician's interest. Explain to the patient, in simple terms, the facts about ulcer so that he may have some understanding of his condition and cooperate better in its management. He should be educated as to the effects of overwork, respiratory infections, and emotional conflicts as well as the benefits of good living habits, moderation in work and play, adequate rest and recreation. Don't just teach the patient to live with his ulcer, teach him to live with himself and his environment. The personal physician is in a strategic position to give moral support by reassurance and encouragement. Allay the fear of cancer, so commonly harbored by the ulcer patient. Make him aware of the early symptoms of the complications of ulcer and advise him to report them at once. Rest is an important part of the treatment during the acute phase. In cases with severe pain, vomiting, or bleeding, hospitalization instead of home care is of great benefit and often mandatory. Hospital care provides better supervision, relief from domestic problems, a prime opportunity for indoctrinating him with the philosophy of ulcer treatment, and the availability of essential facilities for managing emergency complications that might occur.

The diet in ulcer has been a controversial issue for many years. Some of the older clinicians (Leube,[3] Ewald,[4] Einhorn[5] and others) advocated an empty stomach. But Lenhartz[6] and Fenwick[7] recommended hourly feedings of milk and eggs. It was Sippy,[8] in 1915, who re-emphasized, elaborated, and popularized the principles of small frequent feedings of bland foods alternating with antacids together with emotional and physical rest. Sippy[8] asserted that by this regime, maximum neutralization of acid and control of motility (necessary for healing of the ulcer) would be attained. Indeed, the time-honored Sippy regime (or its modern modifications) is still in universal use in the acute stage of ulcer. Sippy's basic principles of a half century ago have stood the test of time. During remissions, however, a strict diet is not essential. In fact, the consensus of clinicians is that strict dietary regulation (except in the active phase) does not influence the natural course of an ulcer nor accelerate its healing.

This has been repeatedly demonstrated by controlled studies. Nevertheless, the Sippy program does relieve the pain and discomfort in the acute, active phase of ulcer and undoubtedly initiates the healing process.

During the acute stage (usually lasting about 3 weeks) we prescribe the Sippy-type regime of 4 ounces of milk every hour, later adding small bland feedings and gradually progressing to the modified bland diet of three meals a day with a glass of milk one and a half hours after each meal and at bed-time for the 6 to 8 weeks, estimated as the healing period. After this, if we are reasonably assured by clinical and radiologic evidence that the ulcer has healed, we feel that severe dietary restrictions are unnecessary. They impose undue hardship and inconvenience. The modern attitude on diet is more liberal than it used to be. Permitting a greater variety and palatability in food is conducive to a higher morale. It also avoids making the patient a dietary invalid as, for example, continuing to restrict him to "baby" foods after the active phase is over.

During a remission, when an ulcer patient has peace of mind, he may eat almost anything with impunity, but when emotionally upset, he can barely tolerate milk. To use a vernacular expression, more often it's what's "eating" him rather than what he is eating that brings on the attack.

Nevertheless, we still advise the ulcer patient to maintain regular, sensible, temperate eating habits. The diet should meet his nutritional requirements and should exclude foods known to disagree with him because of allergy or idiosyncracy. We allow him to eat any food that is not rough, highly spiced, fried or greasy, and that agrees with him. If he develops pain or distress, he is urged immediately to resume the schedule of small bland feedings every hour or two together with rest and other previously prescribed treatment.

Some observers have found that the ingestion of considerable fat-rich dairy products may lead to atherosclerosis and/or obesity. These dangers can be obviated by eliminating cream and substituting skimmed milk for whole milk. Rider[9] and his group, using a pH measuring intragastric capsule, found that skimmed milk was equal in neutralizing ability to whole milk. For years, we have routinely recommended skimmed milk for the overweight ulcer patient.

Physicians differ in their opinion as to the harmful effects of alcohol, tobacco, and caffein-containing beverages. In this connection, Ruffin[10] has said, "If you're from Brazil, you allow coffee; if from North Carolina, you allow tobacco; if from New Orleans, you allow alcohol; if from New England, you allow nothing." Our policy has been to acquaint the ulcer patient with the potential harmfulness of alcohol and tobacco and advise him to abstain from them. During remissions, moderate use of de-caffeinated coffee may be allowed, if tolerated.

Although Grossman[11] and others infer that antacids do not significantly alter the course of an ulcer, nor prevent its recurrence, their use is supported by many factors. The prompt relief of pain is striking and gratefully appreciated by the patient. Besides, neutralization of gastric acid (albeit only for a short time) at least temporarily combats the one known aggressive factor. From the empirical standpoint, the accumulated clinical experience of many years has convincingly demonstrated the beneficial effects of antacid therapy during the active phase of an ulcer.

Though theoretically desirable, complete neutralization is rarely accomplished and apparently is not absolutely necessary for healing of the ulcer. For complete neutralization the pH of the stomach must be raised to 7, whereas at pH of 4.5 or 5 peptic activity ceases.

Besides the strict Sippy program of hourly milk and cream feedings and alkaline powders, the closest approach to complete neutralization is by the continuous intragastric milk-

alkali drip proposed by Winkelstein[12] in 1933. Because of the prolonged discomfort and possible serious local side-effects to the patient, this procedure is recommended only occasionally — and then only in a severe case when the marked hyperacidity cannot be controlled by conventional therapy. In the acute phase of ulcer, antacids, to be really effective, should be given frequently. Since neutralization only lasts from a few minutes to a half hour, the antacids must be given at least every hour to be of value. During the healing stage antacids, in adequate dosage, given four times a day (one hour after each of the main meals and before retiring) are usually adequate. Although with this schedule there is only a small, transient effect on gastric acidity, it is of benefit by virtue of its depressing action on peptic activity as well as relaxing spasms in the pyloro-duodenal region.

During the remission, the use of antacids is unnecessary, except under the following four circumstances: (1) recurrence of ulcer symptoms; (2) during episodes of undue emotional or nervous stress; (3) respiratory infections; and (4) for two weeks before an anticipated recurrence in patients who habitually have seasonal attacks in the spring and fall. In all these instances, the patient is advised to resume small bland feedings every two hours on the even hours and antacids every two hours on the odd hours for about two weeks, gradually progressing through the schedule of the healing stage to that of the remission or quiescent stage.

Sodium bicarbonate, an absorbable antacid, incorporated in the original Sippy powders (and the chief ingredient of many proprietary preparations) is rapidly acting and efficient. However, its drawbacks are the danger of systemic alkalosis on prolonged use and its contraindication for patients on restricted sodium diets. Colloidal aluminum hydroxide, introduced in 1922, is a non-absorbable acid adsorbent and buffer that has given fairly satisfactory results. Because of its constipating tendency it is usually combined with a magnesium salt as the hydroxide or trisilicate. Most clinicians believe that the liquid gel form is longer acting than the more convenient chew tablet and therefore preferable. Some have found the tablets of aluminum dihydroxyaminoacetate sucked continuously had the advantage of sustained neutralization.

Large doses of aluminum hydroxide when mixed with blood in the colon (especially when anticholinergics are used), have been reported to produce impaction, or even complete obstruction. We have had one such case in which the inspissated impacted mass caused a perforation of the colon by pressure necrosis.

Most alumina preparations contain from one to five Grams of sodium per liter. This may be harmful to those on restricted sodium diets. Hydrated magnesium aluminate, calcium carbonate, and milk of magnesia contain insignificant amounts of sodium. The adsorbent affect of aluminum hydroxide may inactivate antibiotics and other drugs, such as steroids. This must be kept in mind when using these drugs in life-threatening situations.

Calcium carbonate is an inexpensive and efficient antacid. It is somewhat unpalatable in unflavored form and is potentially constipating. In prescribing calcium carbonate for extended periods, the possible development of hypercalcemia must be kept in mind and serum calcium determinations should be done periodically. Other rare complications on prolonged calcium carbonate therapy are renal calculi and alkalosis. Excessive intake of an absorbable alkali with large quantities of milk for extended periods, in the presence of impaired renal function, may cause deposition of calcium in the kidneys, soft tissues, and cornea. This complication, known as Burnett's (or milk-alkali) syndrome, is rare, but potentially serious. Early recognition is important. It is reversible by discontinuing the milk and alkali.

There is no ideal antacid. Many clinicians prefer calcium carbonate with occasional

doses of magnesium oxide or hydroxide to counteract its constipating tendency. However, the most frequently prescribed antacid is aluminum hydroxide gel combined with magnesium hydroxide or trisilicate given four to eight times a day depending on the stage of activity of the ulcer.

Anticholinergic drugs may be divided into three groups: (1) the older tertiary amines, belladonna and its alkaloids; (2) the synthetic atropine analogs, Trasentine,® Syntropan,® Pavatrine® and Bentyl;® and (3) the newer group of quarternary amines of which Banthine® was the precursor. Many others have followed, including Pro-banthine,® Pamine,® Pathilon,® Daricon,® Robinul,® Monodral,® Antrenyl,® and Darbid.®

Anticholinergic drugs decrease gastric motility and inhibit gastric secretion by their action on the vagus. In optimum effective dosage, they relieve ulcer pain related to gastrospasm and hyperperistalsis. In the healing process, the action of anticholinergics in decreasing gastric motility is as important as acidity control. The resulting motor rest (with the accompanying slowing of gastric emptying) allows a longer time for the antacids to act. It also reduces hunger contractions and peristalsis.

When the quarternary amines were first introduced in 1950 they were enthusiastically received. Many considered them effective enough to be the sole treatment of ulcer. Time has tempered this view. The consensus now is that these drugs may be useful as an adjunct to, but not as a replacement of, conventional therapy. A few observers reported that the frequency and severity of recurrences were significantly reduced by their continuous administration, especially in duodenal ulcer with marked, persistent hyperacidity. However, most clinicians say that they have no value during remissions and are best used only during the active, symptomatic phase, particularly when antacids and diet fail to relieve pain.

Dryness of the mouth and blurred vision are side effects of anticholingeric drugs. To be pharmacologically effective the dosage should be adequate to produce these side effects temporarily and in mild degree. The dose should then be adjusted to just below this level. Anticholinergics should not be prescribed in patients with glaucoma, prostatic hypertrophy, gastric hypomotility, pyloric obstruction, active bleeding, or peptic esophagitis. Gastric atony and stasis are side effects of anticholinergic medication, occasionally mistaken for pyloric obstruction.

In the acute stage of duodenal ulcer some physicians limit the prescription of a potent anticholinergic to a single adequate dose given before retiring. This usually brings considerable relief due to the drug's ability to depress the characteristic high nocturnal secretion. Some anticholinergics are combined with either a barbiturate or a tranquilizer. This make it difficult to asses their effectiveness inasmuch as sedatives themselves depress motility and spasm. Also, prescribing the components separately allows individualization of the dosage of each. However, for short term use, these compounds may be helpful in providing the synergistically beneficial action of an anticholinergic and a mild tranquillizer or sedative. The newer anticholinergics are more effective when administered parenterally. By thus quickly suppressing both secretory and motor activity of the stomach, they bring immediate and dramatic relief of pain.

Some doctors find the old-fashioned, and less expensive belladonna, usually prescribed with phenobarbital, just as efficacious as the newer compounds. Examples are: elixir of phenobarbital and tincture of belladonna; Belladenal® (Sandoz); Donnatal® (Robins) and Butibel® (McNeil).

As most ulcer patients are tense and apprehensive, mild sedative medication, supplementing the informal psychotherapy, is helpful. Phenobarbital, or one of the minor tranquillizers such as meprobamate, Librium® or Valium,® do allay anxiety and tension, well known aggravating factors in ulcer. As with antacids and anticholinergics, they are most useful in the active phase of ulcer and are best discontinued as soon as possible. Major tranquillizers, with their many potential

serious side-effects, have no place in the treatment of ulcer.

Radiation therapy, used by Palmer and Kirsner[13] in well over a thousand patients as an adjunct in refractory cases, does depress acid secretion, even producing achlorhydria. However, results are not permanent and the procedure may occasionally cause tissue necrosis. Most clinicians are not enthusiastic about this method. We have had no experience with it.

The management of gastric ulcer differs from that of duodenal ulcer by virtue of the 8 to 10 per cent incidence of carcinoma in the former and practically never in the duodenal forms. The characteristic normal or low acidity in gastric ulcer does not call for the vigorous antacid therapy indicated for duodenal ulcer.

Gastric ulcers rarely, if ever, undergo malignant degeneration. In malignant gastric ulcers the malignancy is most likely there from the beginning and may have been slow growing. Recognition of malignancy in a gastric ulcer is often difficult, except when true achlorhydria, radiologic signs, endoscopic findings, or cytology studies are conclusive. For years it was thought that all ulcers on the greater curvature or prepyloric area were malignant, but the many exceptions invalidate this assumption. Neither is the size of the ulcer crater a reliable criterion. If there is any doubt (and if there are no serious medical contraindications) the patient should be given the benefit of surgery. Fortunately, most benign gastric ulcers, even in the elderly, are prone to heal rather rapidly and completely on adequate medical treatment. Jordan[14] has proposed a therapeutic trial for gastric ulcers with questionable malignancy. She advised hospital rest and a strict medical regimen for three weeks. At the end of this period, the findings are reevaluated. If the ulcer crater has not completely disappeared, or if the patient still has pain, or if there is still occult blood in the stool, surgery was recommended. Almost all gastroenterologists and most surgeons generally subscribe to this plan, each adding his own modifications.

Surgery is indicated in peptic ulcer for acute perforation, organic pyloric obstruction, massive uncontrollable hemorrhage, repeated epsisodes of hemorrhage (especially in the elderly arteriosclerotic patients), and suspicion of malignancy in gastric ulcer. Another indication for surgery is the intractable case where the ulcer fails to heal because of irreversible anatomical complications as walled-off perforations into neighboring organs with marked deformities, or severe uncontrollable pain with prolonged disability. Before labeling the case intractable and advising surgery, be sure that the patient has had the benefit of really adequate medical treatment. Although the results of modern surgical treatment of ulcer are generally satisfactory, the small, but significant mortality and the possible distressing sequellae must be kept in mind.

Summary

1. Treatment of peptic ulcer is primarily medical, with surgery indicated for the complications not amenable to medical measures and for the truly intractable cases. Keystone of treatment is a good patient-physician relationship engendered by a sympathetic, understanding attitude on the part of the physician toward his patient.

2. The acute, active phase of the ulcer is managed by rest, informal psychotherapy, restricted diet, and antacids, supplemented by sedatives and anticholinergics as required. During remissions, the patient need not be subjected to the discomfort and annoyance of rigid dietary restrictions and unnecessary medication unless or until he develops symptoms heralding an exacerbation.

3. The therapeutic program should be tailored to the individual patient, whose background, personality, and temperament should be well known to his personal physician. The patient's confidence in his physician is the most potent factor in the successful treatment of peptic ulcer.

A bibliographic listing of citations will be found in the author's reprints.

8 Clifton Place

These tabulations may look like gibberish to pre-war medical graduates. But make no mistake; they offer you a view of the future of medicine

Application Of Computers In A Hospital Clinical Laboratory*

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Computers are now as common a sight in hospital accounting offices as in business offices. However, they have been slow to work into the medical function of hospitals despite glowing predictions and widespread appreciation of their potential in this field. One difficulty appears to be the large amount of work necessary to program the computer, prepare forms, and carry out the initial calculations. The other, equally important, lies in gaining medical acceptance of the results. Here, we will present some examples of computer applications to medical functions in the clinical laboratory. All procedures discussed are operational at the Institute of Laboratory Medicine, Perth Amboy General Hospital. Electronic data processing provides not only facts on a single patient, but also a degree of perspective not readily available with conventional data handling. The entire process can make the laboratory more useful to the patient, the attending physician and the hospital as a whole.

The work here reported was a collaborative effort between the Institute of Laboratory Medicine and the Electrical Engineering Department of Rutgers—The State University. Programs were developed jointly, as was the system design. Early data processing was carried out at the Rutgers computer center, but was switched over to the hospital laboratory proper when the laboratory built up its own computer capability, based on the Spear CLAS 1 and CLAS 300 computers.†

In the clinical laboratory, one finds essentially two kinds of computer applications. First is a continuing analysis of laboratory samples[1] and production of day-to-day patient reports.[3] Second, a retrospective statistical study from many patients[2] involves handling masses of accumulated data for sorting and retrieval for epidemiologic studies and various correlations.[4]

A key problem in all of these studies is the choice of a standardized code which can translate data from English to machine language and vice versa. After some study of available codes we chose the "Systematized Nomenclature of Pathology" (SNOP)[5]. This standardized code includes numeric representation for such entities as body sites, specimen sources, disease, etiology, functional derangements, and morphology. In the bacteriology studies the SNOP was augmented by an antibiotic code using the established standard generic abbreviations. Overall, the SNOP code has proved perfectly adequate.

Bacteriologic Studies

These were essentially retrieval studies from

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† Manufactured by Spear Inc., 335 Bearhill Road, Waltham, Massachusetts.

Figure 1
Typical Retrieval of Bacteria vs. Body Site

Feces			6Y10	
	No. of Patients	95		
	34 P.C.		E. Coli	1341
	5 P.C.		Klebsiella Aerobacter	1390
	4 P.C.		P. Mirabilis	1432
	3 P.C.		Citrobacter	1380
	2 P.C.		Arizona	1370
	2 P.C.		Intermediate Coliform Bact	1450
	2 P.C.		Strep	1680
	2 P.C.		Strep Beta A	1681
	2 P.C.		Strep Alpha	1682
	1 P.C.		A. Aerogenes	1402
	1 P.C.		P. Vulgaris	1431
	1 P.C.		C. Albicans	4304
Urine			7 x 10	
	No. of Patients	142		
	30 P.C.		E. Coli	1341
	14 P.C.		P. Mirabilis	1432
	12 P.C.		Klebsiella Aerobacter	1390
	5 P.C.		S. Epidermidis	1602
	4 P.C.		Shigella	1350
	4 P.C.		Intermediate Coliform Bact	1450
	4 P.C.		Strep	1680
	4 P.C.		Strep Alpha	1682
	2 P.C.		Chromobacter	1300
	2 P.C.		P. Vulgaris	1431
	2 P.C.		P. Morganii	1433
	1 P.C.		Alk Dispar	1342
	1 P.C.		Strep Beta A	1681
Vagina			8100	
	No. of Patients	61		
	62 P.C.		Gram Neg Org	1002
	6 P.C.		E. Coli	1341
	6 P.C.		S. Epidermidis	1602
	4 P.C.		Klebsiella Aerobacter	1390
	4 P.C.		Strep Alpha	1682
	1 P.C.		Intermediate Coliform Bact	1450
	1 P.C.		Haemophilus	1490
	1 P.C.		Strep	1680
	1 P.C.		Strep Beta A	1681
	1 P.C.		B. Subtilis	1733

thousands of patients. The input information consisted of six months' of microbiologic data from Perth Amboy General Hospital. The data contain the following information: bacteria isolated, body site of the isolated bacteria, and sensitivity of bacteria cultured to 32 antibiotics. Retrievals are sorting and totaling operations. The simplest sorting merely correlates body site with the type of bacteria found and the percent frequency of occurrence of each bacteria (Figure 1). One of the interesting results of this retrieval was that almost 10 per cent of the organisms recovered in lung cultures were Myobacterium. This includes sputa yielding positive cultures for M. tuberculosis. Passing this information on to the clinician helps keep him aware of recurring and continuing problems in this geographic area.

The second retrieval, which elaborates on the first, adds sensitivity of each organism in each body site to a large number of antibiotics (Figure 2). From this master retrieval report, an abbreviated physician's report is generated periodically for the hospital staff (Figure 3). This report lists those antibiotics which are 75 per cent or more effective in sensitivity testing *in vitro*.

The utility of this report can be realized by examining the findings of E. coli in urine cultures. In *in vitro* sensitivity testing, effectiveness of antibiotics against this bacterium

Figure 2

Typical Printout of Antibiotic Effectiveness Against A Specific Organism From A Specific Body Site

Bacteria E. Coli 1341

Total Number of Patients for this Bacteria and Body Site is 78

Body Site		Feces		6Y10												
Antibiotics	AN	AF	A	B	CF	C	CX	CL	DM	E	K	L	DP	NY	UP	N
% Effective	53	00	100	100	00	93	100	99	61	100	99	00	100	00	100	99
No. of Patients	78	0	2	1	0	76	4	74	77	1	76	0	1	0	1	77
Antibiotics	NB	OL	OX	P	PB	S	T	TE	FX	G	AP	SS	TH	SSS	FE	HA
% Effective	06	00	100	100	00	82	67	65	100	55	00	00	81	64	100	97
No. of Patients	78	0	1	1	0	77	78	78	76	77	0	0	37	66	76	73

Bacteria E. Coli 1341

Total Number of Patients for this Bacteria and Body Site is 54

Body Site		Urine		7X10												
Antibiotics	AN	AF	A	B	CF	C	CX	CL	DM	E	K	L	DP	NY	UP	N
% Effective	58	00	00	00	100	87	33	100	72	00	96	00	00	00	100	100
No. of Patients	52	0	0	0	1	53	3	50	53	0	52	0	1	1	1	53
Antibiotics	NB	OL	OX	P	PB	S	T	TE	FX	G	AP	SS	TH	SSS	FD	NA
% Effective	00	00	00	00	00	80	70	69	98	58	00	00	72	59	100	94
No. of Patients	53	0	0	1	0	51	53	52	53	53	0	0	39	34	53	50

Figure 4

Typical Surgical Diagnosis Summary Report Retrieval

Patient Hospital	Sex	Age	Ipop	Loc	Pathology Number	MD	Primary Topographical Description	Morphological Etiological, or Functional Description	Date
002065–0	F	38	I	SE4	729–66	18	Cervix Uteri	Chronic Inflammation	2/7/66
002067–0	F	40	I	SW5	730–66	145	Skin	Nevus, Intradermal	2/7/66
002083–0	F	49	I	SW5	731–66	187	Ovary	Follicular Cyst, Nos.	2/7/66
002083–0	F	49	I	SW5	731–66	187	Fallopian Tube	No Pathologic Diagnosis	2/7/66
002083–0	F	49	I	SW5	731–66	187	Cervix Uteri	Nabothian Cyst	2/7/66
002083–0	F	49	I	SW5	731–66	187	Cervix Uteri	Chronic Inflammation	2/7/66
002083–0	F	49	I	SW5	731–66	187	Uterus	Morph. Abnormality, Nos.	2/7/66
002083–0	F	49	I	SW5	731–66	187	Endometrium	Endometrium, Secretory	2/7/66
002083–0	F	49	I	SW5	731–66	187	Endometrium	Hyperplasia	2/7/66
002083–0	F	49	I	SW5	731–66	187	Uterus	Leiomyoma	2/7/66
002080–0	M	48	I	W3	732–66	186	Wrist, Right	Ganglion Cyst	2/7/66
002074–0	F	39	I	W3	733–66	18	Endometrium	Endometrium, Interval	2/7/66
002074–0	F	39	I	W3	733–66	18	Cervix Uteri	Chronic Inflammation	2/7/66
002074–0	F	39	I	W3	733–66	18	Cervix Uteri	Endometriosis	2/7/66
002064–0	F	56	I	SW1	734–66	102	Breast, Nos.	Morph. Abnormality, Nos.	2/7/66
002064–0	F	56	I	SW1	734–66	102	Breast, Nos.	Carcinoma, Nos.	2/7/66

Figure 3
Typical Physician's Report:
Bacterial Antibiotic Sensitivity

Wounds	No. of Patients 106	Effective
Organism	% Isolated	Antibiotic (75%+)
Escherichia coli	19%	Colymycin Kanamycin Furoxone Furadantin Nalidixic acid
Staphylococcus aureus	15%	Cloxacillin Chloromycetin Methicillin Lincomycin Novobiocin Neomycin
Klebsiella-Aerobacter	12%	Chloromycetin Colymycin Kanamycin Furoxone Furadantin Nalidixic acid

Figure 5
Physician Report—Surgical Diagnosis

Dr. I. M. Surgeon	175
Period Covered	1 July 1966—31 December 1966
Diagnosis	*Number of Cases*
Acute Appendicitis	3
Chronic Cystic Mastitis	4
Carcinoma, Breast, Undifferentiated	3
Carcinoma, Skin, Squamous Cell	1
Hernia Sac, Inguinal	10

ranged from 0 to 100 per cent. However, three antibiotics (Furadantin, Colymycin, and Neomycin) successfully supressed growth in almost all cultures. Thus a clinician with a preliminary report of E. coli in the urine could prescribe one of these "most likely effective" antibiotics while waiting for final sensitivity test on his patient's urine specimen.

These results have been so useful to date that the next six months' data has been entered on cards and a one year retrieval is being carried out. To level out the laboratory work load data cards are punched as the test results are completed.

Surgical and Autopsy Pathology

In a normal month, a medium size community hospital (500 beds) will perform about 500 surgical operations and about 30 autopsies. Each of these requires a detailed pathology report which is subsequently filed. The present retrieval of information from these reports is limited. The reason for this is that any attempt to compile data regarding a specific disease or operation necessitates searching through thousands of reports. To facilitate such research—and to prepare hospital reports for the tissue committee—the surgical pathology data were entered into a computer storage system. Abstracting information in the form of reports from these data also fits into our second category—sorting and retrieval of masses of data.

As in the case of the bacteriological investigation, the coding used was the Systematized Nomenclature of Pathology (SNOP)[5]. One interesting aspect of this coding problem was the selection of a dictionary for the computer memory. A dictionary is needed in order to enter or abstract data in English. The SNOP system contains over 14,000 entries, too cumbersome to enter in its entirety into the memory. By judicious abstraction it was found that a dictionary of approximately 700 words was adequate for surgery or autopsy information retrieval.

Two sorting programs have been carried out with the data thus far. These are retrievals from six month and yearly groups of reports. Both are essentially for Tissue Committee reports. The first report groups data by diagnosis and arranges these diagnoses in the numerical order of the SNOP code. The retrieval report (Figure 4) contains the code, the diagnosis in English, and pertinent hospital and patient information. In some reports this has been further expanded to incorporate the physician's operative diagnosis as well as the pathology diagnosis.

A second retrieval, sorting the above information by physician, has been most convenient for the hospital surgery staff. This report is used by the surgeons as a convenient record of the various operations they have performed (Figure 5).

Protein Electrophoresis

A protein electrophoresis test separates proteins of albumin and globulin acccording to

Figure 6

Typical Patient Report: Protein Electrophoresis

Lab No. 02-224

Patient:	Smith, John	Age:	50	Sex:	Male
Hosp No:	7-09678-8	Ward:	Se-5	RM:	599
Physician:	Dr. Doe	Date:	4/12/67		

A/G Ratio 0.86

	Albumin	Alpha 1	Alpha 2	Beta	Gamma	T. P.
GM/100 ML	03.09	00.26	00.94	00.94	01.54	06.7
Per cent	46.1	03.8	14.1	12.8	23.1	
Lower Limit	52.0	01.1	04.8	07.6	08.8	06.2
Upper Limit	69.0	04.8	12.1	15.9	22.6	08.9

Pattern most frequently found in:
Rheumatoid Arthritis and/or Lupus Erythematosus
May also be found in:
Multiple Myeloma or Macroglobulinemia
Rheumatic Fever
Acute and/or Chronic Infection
Myelogenous or Monocytic Leukemia
Polyarteritis Nodosa

_____, M.D.
Pathologist

the electrical charge on the molecules as well as their size and shape. It is an important test, for example, in the diagnosis of: multiple myeloma, macroglobulinemia, exudative enteropathy, nephrosis, cirrhosis, sarcoidosis, and collagen diseases. The data produced by the electrophoresis analyzer consist of the concentrations present in the sample of the total protein, the albumin alone, and four globulin components alone.

Computer usage in this case is the first type mentioned in the introduction, i.e., the production of daily patient reports. The computer takes the input density data, computes percentages, compares these with normal maxima and minima, and by a sequence of logical decisions, similar to a physician's train of thought, deduces the more likely diagnoses. A typical patient report is shown in Figure 6. These results are among the most useful from a practical standpoint since they represent a step in easing the medical workload on the professional level.

The protein and LDH enzyme electrophoresis programs for both "on-line" and "off-line" operation have been completed and running for several months. It should be pointed out that all laboratory tests are programed so that the average laboratory technician can routinely operate the computer and these programs with less than ten minutes' trainning.

Conclusions

The technology exists today for extensive computer applications in the pathology laboratory—with substantial practical benefit. Each problem requires a large amount of program development, but once written these programs can be adopted with little modification by other laboratories. Also the application of computers to medicine offers great opportunities for cooperative programs between the university and the community hospital.

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530 New Brunswick Avenue

A revived interest in medical genetics has characterized the last few decades, and reports like this suggest why.

Carcinoma Of The Breast And Schizophrenia In Two Sisters:

A Case Report

Harold J. Kobb, M.D./Freehold

The cause of schizophrenia, like that of carcinoma of the breast, remains unknown. Most authors, however, agree that there is a genetic factor in both diseases. The exact mode of inheritance is still uncertain in spite of the recognized familial incidence. The occurrence of carcinoma of the *same* cell type, in the *same* breast, in two sisters with well documented schizophrenia promoted the writing of this report.

Case One

An unmarried woman became mentally ill at age 29. She was first admitted to a state hospital after attempting suicide by ingesting iodine. She had auditory hallucinations, and, at times was mute. She improved with electro-convulsive therapy and was discharged eight years later with a diagnosis of schizophrenic reaction-paranoid type. Two years after her release, she was admitted to another institution, where she was again paranoid. She was started on chlorpromazine. X-rays and laboratory studies were all within normal limits. In 1961, she was transferred to the New Jersey State Hospital at Marlboro with a diagnosis of schizophrenic reaction, catatonic type. Her mental condition has somewhat improved but she has remained hospitalized ever since. X-ray and laboratory studies were normal throughout 1964 and 1965.

On January 27, 1966, a mass was noted in the left breast. Axillary nodes were palpable, but chest X-ray was negative. On February 8, 1966, a left radical mastectomy and bilateral salpingoopherectomy were done. The pathologist's report revealed a "sclerosing adenocarcinoma of the left breast with invasion of the pectoral muscle and axillary nodes."

In February 1967, she complained of severe back and left hip pain. It was noted that she was losing weight, and in May 1967 she was transferred to the medical service for evaluation. At this time, she was a hirsute, somewhat obese white female complaining of chest, back, and left hip pain. There was evidence of the previous mastectomy but no lymph nodes were palpable. There was tenderness along the fourth to seventh ribs posteriorly and tenderness along the lumbar spine. X-rays revealed multiple lytic lesions involving the ribs and lumbar spine with destruction of the left acetabulum.

Case Two

The younger sister of Case 1 was admitted to the New Jersey State Hospital at Marlboro on July 22, 1959. She first became mentally ill in 1948, after her sister had been hospitalized. She likewise made a suicide attempt by taking iodine. She exhibited paranoid delusions, believing the "communists were out to get her." A diagnosis of schizophrenic reaction-paranoid type was made.

After a similar admission to another hospital, she was transferred to Marlboro in 1959, and the diagnosis of schizophrenia was confirmed. She was discharged from Marlboro in 1962, but was readmitted on November 19, 1963, at the age of 42. At this time, examination disclosed a hard ulcerating mass in the left breast, attached to the skin. Its dimensions were 4 by 5 centimeters. Several hard axillary nodes were palpable. X-rays of the spine showed destruction of T-4, T-5, and T-6. In January 1964 a needle biopsy revealed adenocarcinoma. Bilateral oopherectomy was performed. In June 1964 flaccid paralysis of both legs developed. On February 1, 1965, a simple mastectomy was done. The report read: "adenocarcinoma of the left breast with invasion of the skin and pectoral muscle." Since then, her paralysis has progressed and because of increasing chest and back pain, she was transferred to the medical service in June 1967 for further evaluation.

Physical examination now showed a bedridden, hirsute woman complaining of chest and back pain. No lymph nodes were palpable. There was evidence of a complete spinal cord transsection with paralysis of both legs and a sensory level at T-4. X-rays indicated destruction and compression of T-3, T-4, and T-5 with lytic lesions involving C-6, C-7 and C-8. There was also a lytic lesion of L-3.

These sisters, both American born, were of Ukrainian descent. Their family life was unstable. Their father had multiple marriages,

* From the Department of Medicine and Surgery, New Jersey State Hospital at Marlboro.

and their mother died at 33 of pneumonia. They lived together, either with their father or a step-brother until their initial hospitalizations. As far as can be determined, there was no family history of mental illness or known cancer.

Most authors agree that there is a genetic basis of schizophrenia. Some[1] regarded the disease as a Mendelian dominant. More recently[2] (based on the large series by Kallman[3]), many have concluded that the mode of inheritance is recessive. A composite of several reports[1] gives the incidence of schizophrenia at 7 to 15 per cent in siblings, 7 to 16 per cent in children of one affected parent, and as high as 40 per cent in children if both parents are affected. However, heredity does not explain the entire pathogenesis. Genetic studies have been criticized because of lack of precise diagnostic criteria in a disease with so versatile a spectrum of symptoms.

In Bleuler's original series,[4] in at least 10 per cent of the cases, there was no familial history of schizophrenia. If a single factor recessive gene were operating, then all of the children of two affected parents should be affected. This has not been borne out.[5] Also, if a single recessive gene were operating, twin studies should be expected to confirm this. Indeed, Kallman's twin studies[2] do show a concordance rate of 86 per cent for monozygotic twins, and 14 per cent for dizygotic twins (the same as for siblings in general). If the identical twins become separated early in life, there still is a 70 per cent incidence of concordance. In the other series,[6] however, up to 25 per cent of identical twin partners do *not* become schizophrenic. It is thus apparent that schizophrenia is *not* regularly transmitted from one generation to another; that it does *not* fit into a typical Mendelian pattern; but that there is a clear cut familial incidence. In view of the general incidence of one to two per cent in all populations, and the differences between monozygotic and dyzgotic twins, an environmental factor alone[5] could not explain these findings.

The frequent occurrence of simultaneous schizophrenia in twins, and also in siblings who are not twins has been noted. This is the interesting condition of *folie á deux* or *folie á trois*. This involves[1] not only a shared psychosis, but also shared delusions and similar symptoms in a long standing association between two or even three persons. The sister-sister relationship seems to have the highest incidence, but there are also reports of brother-sister and mother-daughter pairing. Such cases have also been described in non-related pairs, so most authors feel this is an environmental rather than a genetic phenomenom.

There is no definite evidence that one form of schizophrenia is inherited while another is not.[6] However, the two sisters in the present report had a remarkaby similar onset of their illness. The younger one became symptomatic shortly after the older one was hospitalized. Both attempted suicide by ingesting iodine. They had a long and close association prior to their initial hospitalization and throughout succeeding ones. However, because there is no record of a similar delusional content, they do not fit the typical *folie a deux* pattern.

Although a genetic basis for breast cancer has not been as well documented as in schizophrenia, cancer of the breast occurring in families was reported over one hundred years ago.[7] Recent reports confirm a definite increased incidence in mothers and sisters of affected cases. Penrose and Mackenzie[8] described 510 cases and found 116 with one or more relatives with breast cancer. In surveying the patients' sisters, they found 23 had died with breast cancer, and 24 were known to be under treatment. They also found that there was a strong laterality, and sisters tended to have cancer in the same breast.

Oliver found that among 576 patients 3 per cent of the sisters were affected.[9] In 41 patients whose mothers were also affected, 15 per cent of the sisters also had breast cancer. Morse[10] felt that cancer of the breast has a specific hereditary tendency. Smithers[11] after studying 459 patients, concluded that there is a significantly higher death rate from can-

cer of the breast in the families of patients with that disease; but no higher death rate from other forms of cancer.

Bucalossi and Veronesi[12] analyzed 3988 cases from 1928 to 1956 and found 81 patients with a history of breast cancer in the mother. Of these, they found the incidence of *cancer in a sister to be 15 times the expected frequency.* In patients whose mothers were not affected, they agree with the incidence of 3 to 6 per cent of cancer in sisters as given in previous studies.

Unlike schizophrenia, the incidence of carcinoma of the breast is not constant in various populations, being much lower in orientals.[13] Experimental studies in breast cancer in mice have shown three essentials for the tumor to develop. These are: hormonal stimulation, a genetic factor (evidenced by the development of high incidence strains through inbreeding), and a mammary tumor agent, probably a virus.[13] A viral agent has not, so far, been implicated in human breast cancer but a hormonal factor has, as evidenced by the dramatic response to hormonal ablation. How a genetic factor operates in human breast cancer is unclear. The pattern does not suggest any Mendelian relationship.

As in their psychiatric illness, both sisters had a remarkably similar course with respect to the development of their carcinomas. Both developed a tumor within three years, it was of the same cell type, developed in the same breast, and now they have deteriorated with bone metastases.

The association of breast carcinoma and schizophrenia has not been documented as to causal relationship, although a hormonal basis has been proposed for both illnesses. Attempts have been made to correlate schizophrenia with other known genetic diseases such as glucose-6-phosphatase dehydrogenase deficiency,[14] and perhaps further studies will lead to a better understanding of the genetic mechanisms involved.

Summary

Carcinoma of the breast in two sisters with schizophrenia is reported. Both cases were remarkably similar in regards to their psychiatric illness and in the occurrence of carcinoma of the same cell type, in the same breast. The hereditary aspects of both schizophrenia and breast carcinoma are discussed.

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74 Windham Way

Here is a brief progress report on the Regional Medical Program in our state aimed at improvements in the care of patients with stroke, heart disease, or malignancy.

The New Jersey Regional Medical Program Progress And Plans

Alvin A. Florin, M.D. and James P. Harkness, Ph.D./East Orange*

In October, 1965, when President Johnson signed Public Law 89-239 (the Heart Disease, Cancer, and Stroke Amendments to the Public Health Service Act), $340 millions were authorized to establish regional medical programs throughout the country. This legislation gave each region this general mandate: without disrupting present patterns of medical care, seek ways to assist and encourage new cooperative arrangements among health professionals, workers, and institutions so that the latest advancements in medical knowledge and methods are readily available to all people suffering from heart disease, stroke, cancer, and related diseases. As of October 30, 1967, fifty-four regions in the country had received planning grant awards totaling over $25 millions and had started planning activities.

Regional medical program activities in New Jersey began on December 8, 1965 when the Commissioner of Health invited interested persons to consider the implementation of Public Law 89-239. Individuals representing a wide range of health organizations gathered and stimulated the formation of a non-profit corporation. On February 18, 1966, the New Jersey Joint Committee for the Implementation of Public Law 89-239 was incorporated. This included representatives from The Medical Society of New Jersey, New Jersey Association of Osteopathic Physicians, New Jersey Heart Association, New Jersey Hospital Association, New Jersey College of Medicine and Dentistry, Hunterdon Medical Center, New Jersey State Department of Health, The Academy of Medicine of New Jersey, Health Facilities Planning Council for New Jersey, New Jersey State Department of Institutions and Agencies, New Jersey State Nurses' Association, Princeton University, Rutgers Medical School, and New Jersey State Department of Community Affairs.

In compliance with the Act, a Regional Advisory Group, including individuals broadly representative of the medical resources and consumers of health resources in the region, was designated. The percentage of the 58 members representing specific areas of interest on the New Jersey Advisory Group is compared with the national average in the chart below:

	United States per cent	New Jersey per cent
Hospital Administration	10	5
Public Health Officials	7	5
Practicing Physicians	22	24
Medical Center — School Officials	17	6
Members of the Public	16	26
Voluntary Health Agencies	12	14
Other Health Works	9	17
Other	7	3
	100	100

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The combined initiative and interest of New Jersey's health organizations in developing a statewide heart, stroke, and cancer program stimulated the designation of the entire state as the planning area for the New Jersey Regional Medical Program. Although New York City and Philadelphia medical schools (and their affiliated medical centers) have had important medical influence on New Jersey in the past, the designation of the entire state as a region reflects the emerging statewide medical interests of the representative groups on the executive committee. Furthermore, the development of two new medical schools will not only supply New Jersey with more health professionals, but also act as a stimulus for advancements in medical research and patient care.

On July 1, 1967, the New Jersey Regional Medical Program was funded for one year of planning activity at $297,466 and for a second year for $674,866. Several months before the New Jersey Regional Medical Program had been approved and funded, the Greater Delaware Valley Regional Medical Program, headquartered in Philadelphia, had been funded for a planning area which included the 10 southern counties in New Jersey. With the subsequent designation of the entire State of New Jersey as the planning area for the New Jersey Regional Medical Program, these 10 counties became part of the planning area for both programs. This unusual departure from previous federally funded programs is explained by the Director of the Division of Regional Medical Programs, Dr. Robert Q. Marston, in a recent speech as follows.[1]

> Regions are self-delimiting, and as a Program progresses from planning into operational activities, some Regions may merge, and others might divide. Such decisions will be made by Regions, subject to approval by the National Advisory Council and the Surgeon General, as they find themselves either unwieldy or lacking in some vital element.

Development of the Planning Activities

By November 1, 1967, the Program Coordinator, following the original planning grant proposal, had hired a core staff and had appointed "task forces" on heart disease, stroke, cancer, and education. By January 1, 1968, preliminary committee reports outlining suggestions and recommendations for operational activties had been received and are summarized in the Chart.

The Regional Medical Program staff plans a series of workshops to bring suggestions for operational programs to practicing physicians, medical school staffs, and health facility administrators throughout the state. In addition, these meetings will enable medical leaders of the local community to initiate new suggestions for operational activities. This program provides a basis for existing health agencies, medical schools, practicing physicians, and administrators of hospitals and other health facilities to work together to generate concrete proposals which will strengthen diagnosis and treatment for those in New Jersey with heart disease, stroke, cancer, and related diseases.

It is anticipated that, by the end of 1968, most of the proposals received will have had local review and the Program staff will have been able to draw up working protocols to be submitted to the Advisory Group of the New Jersey Regional Medical Program. As indicated in the legislation, Advisory Group approval must be given before proposals can be submitted to the National Institutes of Health for funding.

Somewhat apart from the original design and the activities of the task forces to date has been a new expression of interest at the state and national level in solving urban health problems. In December, 1967, the New Jersey Regional Medical Program considered the role of the program in the many new urban health proposals, particularly Model Cities legislation and Office of Economic Opportunities health activities. Officials from the New Jersey Department of Community Affairs, national experts, and Division personnel from the Regional Medical Program all spoke on the efforts now underway to increase the availability of health services in the urban

[1] Regional Medical Programs — A Progress Report by Robert Q. Marston, M.D. and Alexander M. Schmidt, M.D. The American Public Health Association, October 26, 1967, Miami Beach.

areas of this country. This concern led to a decision to submit a supplementary proposal which will provide funds to assign an urban health planner to each of the designated Model Cities areas in New Jersey (Newark, Trenton, and Hoboken) to assist in health planning particularly as it relates to heart disease, stroke, and cancer.

Who is eligible to receive funds for operational programs?

Meeting the unique needs of the region has been the dominant theme throughout the development of the regional medical program. This individual approach, coupled with the broad goals of the program, gives each prospective applicant a wide range from which to approach the objectives of the law and fulfill his particular requirements for strengthening medical care in heart, stroke, and cancer in his locality.

There are, however, general features of any proposal for regional medical program funding that must be considered.

1. Projects must be concerned with heart, stroke, cancer, and related disease.

2. Activities proposed should foster new cooperative arrangements among those responsible for the delivery of health care.

3. Where feasible, projects should provide a link between new medical knowledge and the application of this knowledge to patient care.

Summary

It is the basic intent of the regional medical program staff to stimulate new cooperative arrangements among physicians and health institutions and organizations so that the latest developments in heart, stroke and cancer will be applied promptly to all patients throughout New Jersey. The program has started with the active involvement of practicing physicians, hospital administrators, and others in the health field. Task force committees of these groups have developed recommendations which will be reviewed by all interested health professionals and workers throughout the state during the next year.

Recommendations For Operational Grants

Heart

1. Statewide Educational Program in Cardiopulmonary Resuscitation.

   To promote knowledge and expertise in technics of CPR for professionals, allied health personnel and lay groups in all communities throughout the state.

2. Coronary Arteriography — A Program for Training and Implementation.

   It is proposed to utilize coronary arteriography as a definitive tool for the diagnosis of coronary heart disease and to provide precise anatomic evaluation for surgical correction.

3. Evaluation of Pacemaker Status.

   To develop a method for evaluating the status of implanted pacemakers by external means thus detecting incipient pacemaker failure and allowing elective replacement of necessary parts.

4. Programs Related to Intensive Coronary Care.

   a. To develop traveling team programs that offer technical and teaching assistance to hospitals which are planning to provide new intensive care facilities.

   b. To develop programs that promote training of increased numbers of professional nurses to service intensive coronary care facilities.

   c. To develop programs that promote teacher training for professional nurses to provide in-service education manpower for continued staff development in coronary care units.

   d. To promote the development of new training courses or centers for staff development for coronary care units in new areas of the state.

5. A Cooperative Program for Cardiac Care and Education in Small Community Hospitals.

   To establish a cooperative program among a group of small local hospitals for delivering optimal medical care to the cardiac patient and for providing relevant continuing education to all persons concerned with this care.

Cancer

1. Demonstration of the Role of Tumor Conferences in Cancer Treatment.

   To demonstrate the contribution of regularly held tumor conferences as a means of improving the diagnosis and treatment of cancer and as a valuable aspect of continuing medical education.

2. Cancer of the Breast Symposia.

   To provide a medium for the RMP to focus on a specific cancer with high degree of curability. To show the importance of this method of continuing education in the reduction of deaths from cancer of the breast.

3. Continuing Education for Nurses on Cancer.

   To upgrade the quality of nursing care of cancer patients.

4. Scholarship in Oncological Nursing.

   To provide a means for upgrading practice of selected professional nurses affiliated with cancer detection and treatment centers until such time as New Jersey can develop and support a Continuing Education Program in the state.

Stroke

1. A Pilot Stroke Program.

   To effect a cooperative arrangement among a group of hospitals of a region for comprehensive care of all patients with stroke and to bring to the attention of the medical and allied health personnel of these hospitals the modern technology employed in such care.

2. Aspects of an Educational Program in Stroke for Physicians.

   To bring to the attention of the practicing physicians of a region the modern methods involved in the comprehensive care of patients with stroke.

3. A System of Regionalization to Deliver the Best Health Services to Stroke Patients.

   To designate a responsible unit for stroke in a functional and geographic region to meet the needs of the region.

4. A Study of Hyperbaric Oxygenation.

   To evaluate the role of hyperbaric oxygenation (HBO) in the treatment of patients with stroke during the early phase of illness.

5. Community Hospitals in Need of Personnel for Rehabilitation Unit.

   To provide cooperating personnel for upgrading the rehabilitation services in smaller hospitals of a region. These facilities to be under the supervision of a single physiatrist.

6. Continuing Education for Nurses — Stroke and Rehabilitation.

   a. To improve the delivery of comprehensive nursing care to stroke patients in every stage of illness in the variety of settings where they receive care.

   b. To promote development of a rehabilitation specialist for leadership skills in patient management as well as utilization of allied health personnel in a comprehensive approach to the care of the stroke patient.

Related Diseases

1. Multiphasic Screening for Heart Disease, Cancer, Stroke, and Related Diseases.

   To establish a streamlined partly automated multiphasic screening diagnostic facility — hospital based — to serve a partly urban, partly rural population for improved diagnosis and treatment of early phases of heart disease, cancer, arteriosclerosis and allied disorders.

2. Chronic Renal Disease Program.

   To determine the extent of chronic renal disease in New Jersey especially with regard to the number of patients suitable for hemodialysis and transplantation programs.

Continuing Education

1. Academy of Medicine — Graduate Medical Education.

   To organize and operate 10 symposia or programs on intensive care of the cardiac, 5 on modern concepts of cancer, and 5 on stroke.

2. Medical Dial Access Library.

   To provide pithy, up-to-date medical information on a round-the-clock basis via statewide telephone hookup.

3. Medical Film Cartridges.

   To present graphic, well-developed medical films of short duration to physicians in a comfortable and relaxed atmosphere as part of a continuing education program.

Urban Health

1. Demonstration of a Hospital-Based Comprehensive Care Clinic Service in an Urban Setting.

   To expand existing outpatient clinic services into a comprehensive medical care clinic embodying the principle of the hospital as a community health center to serve the community with special emphasis on reaching those unable to provide such services for themselves.

2. Demonstration of a Hospital-Based Comprehensive Care Clinic in a Densely Populated Urban Area.

   To provide, through a re-organization of present out-patient clinic services, comprehensive medical care services to residents of an area adjacent to the hospital including private patients, indigent and medically indigent patients, and other selected special population groups; such cases to include primarily physician care, referrals to hospital-based specialists, preventive medical care, and emergency care; and to provide in conjunction with this clinic an approved 3-4 year Residency in Comprehensive Care for postgraduate medical education.

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NEW JERSEY DOCTORS' NOTEBOOK

Address of Retiring President*

Louis K. Collins, M.D.

Last year, when delivering my inaugural address, I faced a restive audience preparing to leave Atlantic City. Now I have a fresh, eager, "captive" audience in attendance. I have instructed the sergeant-at-arms to lock the doors and let no one depart. So place the cotton in your ears, sit back, and relax.

I do not wish to repeat what I stated in my annual report — you may peruse that at your leisure. But I would request that you carefully read all of the reports. They show what a mountain of work is accomplished by our officers, councils, and committees. None of this would be possible without our most efficient and capable staff. My personal thanks go to them all for the inestimable assistance they gave me — from the incomparable Dick Nevin to Mr. Lippincott, who always had my iced coffee ready at lunch time.

As you probably already know, we are losing two of our most efficient staff members this year because of resignation. Our legal counsel, after ten years, and Terrie Goeke, an eighteen-year veteran, are departing. We shall miss them greatly — will you please give them a hand. It is also a good thing that our Convention Manager, Mrs. Marion Walton, waited until most of the arrangements had been made by her, before permitting her gall bladder to perforate. Our best wishes for a speedy recovery, Marion, and thanks for making this Convention possible.

I made mention of the medical or health manpower shortage at the Golden Merit Award ceremonies this afternoon.† To me, this is one of the greatest challenges of our time. I am sure that the solution is not just producing more physicians and ancillary personnel. There must be a better distribution and utilization of the resources that we now possess. And if we do not solve this problem — or at least make an honest attempt, even if we step on some toes in the process — legislation will surely try to do it for us. Everyone knows we already have too much government edict and fiat and plans. We must attempt to bring reason out of chaos and to look carefully at the entire "ball of wax."

I should like to digress a moment and speak of freedom, of which we hear so much today. The freedom I prize most highly is my freedom to practice medicine as I see fit. I believe that I should have the right to practice solo, in a group, as an industrial physician, as a college doctor, as a full-time man in a hospital, or any other way I choose, so long as I practice good medicine in the best interest of the people I treat and serve. If HEW Secretary Wilbur Cohen, or any of his fellow social planners attempt to legislate or circumscribe the way I practice medicine, I will fight tooth and nail for my freedom. And I trust that every physician, even every thinking voter, will fight with me, for his freedom also is at stake. For some areas and some physicians group practice may be best; it may be more economical of time and man power; it may have other advantages. However, I hold to the premise that I, as a free American citizen, alone have the right to decide how and where I will practice medicine. This is basic to my credo of personal freedom.

It has been my privilege to participate several times recently, at the Woodrow Wilson School of Public and International Affairs at Princeton University, in roundtable discussions of the total issue of medical care and facilities in the State of New Jersey. I sincerely hope that some real workable ideas will result from this free exchange of thought. Undoubtedly this group will report to the Governor in the near future.

* Presented before the House of Delegates, first session, May 18, 1968.

† See page 270, this issue

On April 16, our Legal Counsel, Robert Backes, and I participated on a panel in Columbus, Ohio, at a joint meeting of the Columbus Academy of Medicine, Franklin County Medical Society, and the Columbus Bar Association. The affair was attended by 500 persons, and the subject for discussion was our Impartial Supreme Court Rule Panel System in New Jersey. Our presentation was well received, and a lively question-and-answer period followed the symposium. Apparently the efforts of the Medical Society over a ten-year period were not in vain. We do have a workable plan that other areas are attempting to emulate. I trust that all of you who serve as sub-panel members or expert witnesses will continue to do your best to make this innovation of ours really become a model for the entire country. By the way, none of your dues monies went for this trip; Columbus paid the freight.

In conclusion, I should like to tell you all why May 18 shall always remain deeply rooted in my memory, for three very special occasions. The first, of course, is that I reach the culmination of my presidential career by presiding over this 202nd Annual Meeting. You have accorded me a great honor, and I hope that my conduct of the office has been deserving of it. The second memorable May 18 goes back 23 years to 1945, when I once again set foot on United States soil, having been on foreign duty for almost two years. I sent Emmy a warning cablegram, which arrived five days after I flew in. The third May 18 was a year earlier in 1944, when I really came to know God. While lying on the ground beside a C-47 aircraft on a tiny airstrip in Burma, bleeding from multiple wounds, many thoughts flash before one's eyes. Is my life insurance all paid up; will my wife and two little girls be all right; is the GI I was helping carry off the plane dead beside me, or does a faint spark of life still linger? As the tracers from strafing Japanese Zeros trying to finish the job come nearer and nearer, one gets much closer to the Almighty.

This is my story of three vivid May 18ths. I shall hold them dear as long as I live.

Trustees' Minutes

April 21, 1968

A regular meeting of the Board of Trustees was held on April 21, 1968, at the Executive Offices in Trenton. For your further information, detailed minutes are on file with the Secretary of your county medical society. A summary of the significant actions follows:

J. Howard Hornberger, M.D. . . . Adopted the following memorial resolution and authorized a contribution, in the amount of $50, to the Medical Student Loan Fund in memory of Dr. Hornberger:

J. HOWARD HORNBERGER, M.D.
1896 — 1968

Whereas, Almighty God has seen fit to summon from our midst His good servant and our beloved colleague, J. Howard Hornberger, 156th President of The Medical Society of New Jersey; and

Whereas, for almost five decades Dr. Hornberger gave to the practice of medicine his excellent best, manifesting always sage and humanitarian qualities that made him respected and loved as a physician and a man; and

Whereas, his death brought to a close a lifetime of exemplary service to medicine and his fellowmen; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey record profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting, and another copy — suitably prepared — be presented to his bereaved family.

MSNJ Acting Secretary . . . Designated Jerome G. Kaufman, M.D. as Acting Secretary of MSNJ for the duration of the illness of the Secretary, Marcus H. Greifinger, M.D.

Academy of Medicine Library . . . Directed that MSNJ representatives to the Academy and the chairmen of the Committees on Medical Education and Finance and Budget meet with representatives of the Academy to explore the suggestion of amalgamating both medical school libraries with the Academy Library, considering the financial aspects and the possibility of new headquarters, and prepare appropriate recommendations, including financial estimates, for the Board.

New Jersey Heart Association . . . Directed that the New Jersey Heart Association be informed that MSNJ endorses its efforts to have the Heart Association serve as a coordinating agency throughout the state for the purpose of providing teaching faculty in hospitals not having active cardiopulmonary resuscitation programs, and implementing those that do; and requested a copy of the "protocol" (to be submitted by the New Jersey Heart Association to the Regional Medical Program). This proposes that the Heart Association act as a coordinating agency in a cooperative venture with physicians, dentists, nursing associations, hospital associations, first-aid squads, and industrial units. Upon its receipt, the Board will discuss the "protocol" and make a decision.

Symposium on Medical Communications . . . Agreed, at the request of Rutgers University and the New Jersey Press Association, to cosponsor a one-day symposium on medical communications in the fall, under the auspices of Merck, Sharp and Dohme.

New Jersey Society of Thoracic Surgeons . . . Directed that the New Jersey Society of Thoracic Surgeons be added to the official list of specialty societies having intermediaries with MSNJ.

Humanitarian Scientists Award . . . Authorized the Society's cosponsorship (at the invitation of the Humans for Animals and Humanity Society and at no expense to MSNJ) of a Humanitarian Scientists Award, which will be given to an outstanding citizen of the bio-medical community. A request was also made for nominations.

External Cardiopulmonary Resuscitation . . . Referred a "revised" version of the previously approved statement on "External Cardiopulmonary Resuscitation (including defibrillation) and the Registered Professional Nurse" to the 1968 House of Delegates for action.

Medical Student Loan . . . Approved the following recommendation from the Committee on Medical Student Loan Fund:

That in light of the changed economy, the maximum yearly individual loan be increased from $1,000 to $1,500 and the required life insurance be increased accordingly.

Academy of Ophthalmology and Otolaryngology . . . Approved A-639, provided (1) the term "ophthalmic" assistant is amended to read "ophthalmological" assistant; and (2) a statement is appended to the measure which will set forth the background and necessity in the public interest for this legislation. The following is pertinent to the above action:

Representatives of the Academy of Ophthalmology and Otolaryngology reported that orthoptic-pleoptic eye clinics in the state are being closed by order of the Board of Medical Examiners because of the use of legally unqualified technicians. Legislation (A-639) has been introduced to give legal protection to such technicians so that the clinics can be reopened without delay. The bill exempts opthalmic assistants from certain prohibitory provisions of Chapter 9, Title 45 of the Revised Statutes concerning the practice of medicine. Assurance has been given to the Society (through the officers of the Academy of Ophthalmology and Otolaryngology) that once this measure is passed, efforts will be directed for passage of the Society-sponsored measure (S-589) to grant legal protection to medical, surgical, and x-ray technicians working under direction of a licensed physician.

Finance and Budget Committee . . . Approved the report of the Committee on Finance and Budget, including recommendations to the 1968 House of Delegates. The entire report is included in the Committee's Annual Report and will be submitted to the 1968 House of Delegates, and is, therefore, not reprinted here.

Medical Defense and Insurance . . . Approved the following recommendations from the Committee on Medical Defense and Insurance:

(1) That Employers Insurance of Wausau be designated as the official professional liability insurance carrier for MSNJ for 1968-1969.

(2) That Joseph A. Britton be designated as MSNJ's official broker for its professional liability coverage.

Council on Legislation . . . Adopted the following recommendations from the Council on Legislation:

(1) That the Committee on Emergency Medical Care communicate with a selected list of individuals (supplied by the Council) to bring about the piecemeal legislative amendments. (Needed to enact model ambulance legislation)

Note: Upon investigation the Council concluded that it would be impossible to enact the Model Ambulance Service Ordinance into law with one measure. This had been approved by the Board on October 15, 1967 and referred to the Council on Legislation for implementation. The council thus made the above recommendation.

(2) That MSNJ adopt as its offical position the actions indicated (on the senate and assembly bills considered by the Council).

Note: The entire list of bills considered by the Council on Legislation this year appears in the regular and supplementary annual reports of the Council, and is not included here.

Public Health . . . Approved the following recommendations from the Council on Public Health:

1. Air Pollution Control:

(a) That MSNJ support Chapter 11 of the New Jersey Air Pollution Control Code — Control and Prohibition of Air Pollution from Incinerators — and request an early effective date.

(b) That MSNJ call upon the State Department of Health to seek alternative methods, freer from pollution effects than incineration and capable of transmitting useless solid waste to useful products.

(c) That MSNJ urge the Governor to appoint a representative from the Society on the Clean Air Council of the New Jersey State Department of Health; and inform the Governor that MSNJ is prepared to make nominations.

(d) That Dr. Roslyn Barbash be designated as the Society's official representative to the 51st AMA Congress on Environmental Health, to be held in Chicago in April 1968.

2. Cancer Control:

(a) That each hospital be requested to designate an officer with whom the Society can deal in accumulating information concerning hospital cancer control activities.

(b) That the Committee be authorized to direct a letter to the chief of staff of each hospital, requesting the name of that officer.

(c) That — at the beginning of each year — the Committee ascertain, in a letter to the chief of staff of each hospital, whether the previously designated officer is still the person to communicate with.

3. Conservation of Vision:

(a) That all general non-proprietary hospitals, regardless of derivation, be invited to participate in the 1968 Eye Health Screening Program, provided the physician-in-charge is a member of The Medical Society of New Jersey.

(b) That MSNJ cooperate with the Academy of Ophthalmology and Otolaryngology in inviting all interested members of The Medical Society of New Jersey to man the eye mobile unit on a one-day voluntary basis.

(c) That MSNJ endorse, as a necessity in New Jersey, the establishment of centers for research, diagnosis, and treatment of reading and learning disabilities.

Emergency Medical Care . . . Approved the following recommendations from the Committee on Emergency Medical Care:

(a) That the program of the State Department of Health for two-way communications between ambulances and hospitals, currently being developed, receive official endorsement of MSNJ. (Such endorsement would not involve financial or staff assistance.)

(b) That MSNJ cosponsor, with the Department of Health, an inventory of the response capabilities of ambulances in New Jersey.

Project Hope . . . Approved the granting of a $1,000 fellowship to David B. Scanlan, M.D. (Atlantic County) at the beginning of his tour of duty with the *S.S. Hope* (Ceylon, October 13 to December 13, 1968).

. . . Approved the following recommendation in accord with the Committee on Project Hope whose opinion is that the "pilot basis" of this project should be ended, that the program should be made a continuing one, and should include physicians who are volunteering for non-remunerative service in Vietnam:

That Project Hope and Vietnam be established as a joint continuing program of The Medical Society of New Jersey, subject to any subsequent modification by the House of Delegates; and that a maximum of six fellowships be awarded annually on a "first-come" basis, each carrying a stipend of $1,000 for a 60-day tour of duty abroad the *S.S. Hope,* her sister-ship, or *voluntary* non-service connected service in Vietnam.

William F. Costello, M.D. . . . Directed that an appropriate letter of congratulations be presented to Dr. William F. Costello at the Dover Chamber of Commerce dinner, when he will be honored as "Man of the Year."

Dr. Donnelly To Head Blue Shield

Dr. Joseph P. Donnelly, medical director of Margaret Hague Maternity Hospital, Jersey City, has been named as president of Medical-Surgical Plan of New Jersey (Blue Shield). Dr. Thomas J. White of Jersey City, the Plan's board chairman, had also been serving as interim president following the death, January 4, of Dr. Nicholas F. Alfano, Blue Shield's first full-time salaried president.

The new Blue Shield president will serve on a part-time basis until he has concluded phasing out his activities at Margaret Hague Maternity Hospital, which he expects to accomplish by June 15.

Dr. Donnelly has been a Blue Shield trustee since 1953. He is chairman of the public relations committee, and a member of the personnel and long range study and planning committees. He also has been active in the affairs of our Medical Society as well as in the American Medical Association. A former trustee of The Medical Society of New Jersey, he is chairman of its delegation to the American Medical Association. He is a former president of the Hudson County Medical Society.

Born in Jersey City, Dr. Donnelly received his A.B. from Catholic University and his M.D. from Yale. He served his internship at Duke University Hospital, and his residency at Margaret Hague Maternity Hospital. He was acting chairman and professor of obstetrics and gynecology at Seton Hall University Medical School, and assistant clinical professor of obstetrics and gynecology at the College of Physicians and Surgeons of Columbia University.

Dr. Donnelly is a diplomate of the American Board of Obstetrics and Gynecology, a Fellow of the American College of Surgeons and of the American College of Obstetrics and Gynecologic Society, and a member of the New Jersey Obstetrical and Gynecologic Society. In 1965 he was given Catholic University's achievement award in medicine at the University's diamond jubilee celebration.

You and Pollution Control*

Pollution in New Jersey of air, water, and land is terrible. It is under reasonable control, but it must get a *lot* better and must be controlled to a far greater degree.

Pollution relates (1) directly to people, (2) to the density of people, (3) to the production of energy, (4) to people's activities at home, at work, and at play, (5) to the density of motor vehicles, and (6) to the types and density of industry. New Jersey sets records in nearly all these parameters.

We have, and are, changing our concepts greatly with respect to all types of pollution. For one thing, we are getting back to where we, as public health workers, may have temporarily forgotten our training, i.e., we are again intensifying our efforts at prevention! This is tough, but it has to be done. It means better, more rigid, more comprehensive preplanning of sewerage and water systems and more control over industrial planning. It means more licensing and possibly operating certificates. It means more preview of plans. It means no more lousy incinerators in apartments and in homes. It means better heating of homes and factories with lower sulfur fuels. It means local control of leaf collection and burning. The list is a long one.

There was a federal enforcement air pollution conference in New York dealing with

* Reprinted from the May 1967 issue of *Public Health News,* the monthly publication of the New Jersey State Health Department. This article is from a presentation by Roscoe P. Kandle, M.D., State Commissioner of Health, before the 56th Annual Conference of State and Local Health Officials of New Jersey, Princeton, New Jersey, March 30, 1967.

interstate air pollution in January which lasted two weeks.

A lot came out of this, some of which was good. Let me briefly summarize:

(1) Both we and New York share a gigantic air shed which we both pollute extensively.

(2) The wind blows both directions, so we pollute each other — incidentally, roughly equally.

(3) With respect to sulfur dioxide, there are in New Jersey three major sources:

(a) people — in heating homes, apartments, and factories,

(b) power production — mostly electricity and steam,

(c) industrial processes.

These three sources contribute roughly equally, i.e., each about one-third.

The myth that there are a few "bad guys," i.e., a few major polluters, was destroyed. Almost all of us are polluters.

(4) There was no evidence of interstate air transport of carbon monoxide pollution, but cars travel in both directions. The carbon monoxide situation is serious and getting worse. Most of us polluted the air today with respect to carbon monoxide and other hydrocarbons with our cars.

(5) Drastic reduction to low sulfur fuels is probably the remedy to really get control of sulfur dioxide.

What have we, i.e., the State Health Department, done about pollution?

(1) For one thing, we have been working at stream pollution for 70 years, otherwise we wouldn't have much usable water now.

(2) We have created a new *Division of Clean Air and Water* with Richard Sullivan as the director. This Division includes air, stream pollution, and solid waste disposal controls. Because of the years of working at air pollution, every major power producer and most other plants have air pollution control equipment installed and in operation. Now standards are higher and there is much more to be done, but again, the present state, which certainly needs improvement, is commendable for the progress made so far.

We have changed and are changing our concepts of stream pollution control and water and waste treatment. We have a new understanding of rivers as a whole and of their total ecology. We are insisting on stream valley, regional, and intermunicipal systems. We have no patience with septic tanks or package plants. Currently, we are making grants and loans for stream valley, regional, and intermunicipal sewerage systems of about four million dollars a year. Next fiscal year, we hope to have state construction subsidy monies, as well as more federal construction funds.

The total pollution enforcement program, particularly through the Office of the Attorney General, has been greatly strengthened. Here is a brief resume of relatively recent court actions through the efforts of our three Deputy Attorney Generals, two of whom are full-time with our Department:

During the past six months, 28 separate actions for violators of the state's air pollution control laws and regulations have been presented to the courts. All court decisions have been in favor of the state. Only five of these cases are still pending. Fifteen of these cases were for recovery of penalties, totaling $7,500. The remaining 13 cases resulted in permanent injunctions being obtained that supported orders issued by this Department and directed to air polluters. These polluters included foundries, chemical companies, rubber companies, salvage operations, municipal refuse disposal areas and incinerator operators.

Similarly, during the past six months, seven separate actions have been instituted and permanent injunctions obtained against violators of the state's water pollution and potable water control laws. Orders were en-

tered by the court in all seven cases directing these violators to take certain specific action recommended by the Department to correct present conditions and prevent further violations of said laws. These violators included dye works, chemical companies, pigment manufacturers, metal processing companies, and municipalities.

Please recognize that even more than in the past we have our orders to enforce and we shall! We shall be equitable but firm.

I cannot refrain from drawing your attention to page 4 of the November-December 1966 *Air-San*† newsletter, which gives the actual data on the air at Raymond Boulevard in Newark before, during, and after the Thanksgiving inversion. They are truly fascinating. There are dozens of lessons here.

Let me point out:

(1) The sulfur dioxide went down after the alert was called. We took vigorous action!

(2) Newark always shows high carbon monoxide levels — this is a densely trafficked area!

(3) Carbon monoxide stayed up and was very high — everybody was traveling.

(4) Only the winds which eventually overcame the inversion cleared up the dirtiness — labeled "smoke."

Air pollution and solid waste disposal and stream pollution control demand the full and coordinated efforts of all of us. Local health departments can:

(1) control open burning,

(2) pass and enforce the model Smoke Control Ordinance,

(3) report air pollution violations to the State Health Department,

(4) follow-up on state orders or perform other surveillance,

(5) operate decent sanitary landfills,

(6) establish leaf collection systems and control leaf burning.

We do not encourage your trying yourselves to do the intricate and expensive laboratory tests which you can request from us.

We are trying hard to win the two court cases which have challenged the legality of local air pollution ordinances. Furthermore, we support the proposed new legislation to let municipalities or other units have local ordinances stricter than the state codes. However, this process must be safeguarded. The worst thing that could happen to New Jersey would be a proliferation of detailed local air pollution laws with varying standards. Air pollution transcends municipal boundaries and needs, in our opinion, basically a state approach from a legal point of view, with the kinds of exceptions I noted earlier. Meanwhile, you have your nuisance ordinances and many of you have done better than we could in specific instances through the judicious use of these procedures.

We have three air laboratories, one on Raymond Boulevard in Newark, one in Bayonne, and one presently in Ancora. The Newark data are being telemetered to Trenton constantly. Come and visit the air labs and the set-up on the 6th floor of the Health — Agriculture Building in Trenton. There is no better in the United States.

We have a monitoring and alert system with New York.

Pollution control is your job, too. In fact, it is a major part of your job locally. Often you have information far earlier than we. You ought to get abatement locally and promptly as possible, as you you have for years. When we need to be partners, we shall be. Neither of us can afford to pass the buck. Pollution has got to be controlled to the best of our ability. It is not going to go away. Without our best efforts, pollution will get worse.

† Bimonthly publication of the Air Pollution Control Program.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of April:

	April 1968	*April 1967*
Aseptic Meningitis	11	12
Primary Encephalitis	5	2
Post-Infectious Encephalitis	1	2
Hepatitis, Total	119	203
Infectious Hepatitis	108	168
Serum Hepatitis	11	35
Malaria (Servicemen)	9	7
Meningococcal Meningitis	13	24
Mumps	417	*
Measles	94	70
German Measles	392	*
Salmonellosis	47	35
Shigella	12	20

Measles

Measles continues to be an important communicable disease problem in New Jersey. One hundred and ninety-one cases have been reported for the first four months of 1968. In March, an intensive immunization program was undertaken in Newark where 6,800 children were vaccinated. There is now a law in New Jersey which permits school boards to make measles immunization a prerequisite for school entrance. Recently we sought to find out how many school districts require measles immunization for school entrance. Three hundred and thirty-three school districts out of 590 districts responded. Of those, 115 districts (about 50 per cent) required measles immunization or a history of measles for school entrance. One hundred and ninety-two did not require measles immunization and 26 encouraged measles immunization.

Erythema Infectiosum (Fifth Disease)

In the last issue of the Communicable Disease Summary, we reported the occurrence of Erythema Infectiosum (Fifth Disease) in New Jersey and described the clinical picture. Subsequently we have heard of cases in other parts of the State. This widespread occurrence of Fifth Disease is unique and we would like to hear about any cases which may occur. Please call 609-292-5590 to report any such outbreaks.

*Not reportable until after October 1967.

Tetanus

While tetanus continues to decline in absolute numbers of cases and in incidence, it remains a disease with an impressive mortality. The national case fatality ratio is 68 per cent, but it is greater than 75 per cent at the extremes of age. During 1967, there was one fatal case of tetanus in a 63 year-old New Jersey man.

The peak incidence of the disease in the United States is among the very young and elderly. Since 1900, death rates in the neonatal group and the under 30 group have decreased by a factor of 50. However, the death rate from tetanus in the over 70 age group during the same time interval has only decreased by a factor of 5. This reflects the increased severity of tetanus in the aged as well as the low levels of immunity in this segment of the population.

There should be a continuing effort on the part of all physicians to maintain tetanus prophylaxis among adults. The current recommendation is for a tetanus toxoid booster every ten years. Whereas many males have been vaccinated in the military, the elderly female population is largely unvaccinated.

Salmonellosis

In mid-February, a common source foodborne outbreak of gastroenteritis due to Salmonela derby was investigated at a university in New Jersey. Several hundred students were involved in the outbreak.

A questionnaire was distributed to a sample of the ill students and a control group of non-ill students. Comparison of information supplied by the ill and non-ill students implicated an evening meal served at one of the university's four cafeterias. A similar analysis of the foods served at that meal strongly suggested that London Broil flank steak was the offending food item. This hypothesis was confirmed by cultures of samples of the cooked meat which also grew out Salmonella derby.

A sanitary inspection of the cafeteria facilities showed several possible sources of contamination of the meat after it had arrived in the kitchen, and subnormal holding temperatures which could have allowed multiplication of the bacteria.

The role of the State Health Department in food-borne outbreaks of disease is first to be certain that the outbreak has ceased and that the causative agent has been identified so that patients receive the correct medical attention. A second and equally important role is to identify the source of contamination. If a contaminated commercially available food product is the cause of an outbreak, it must be promptly pursued and removed from the market so as to prevent other outbreaks.

Regional Medical Programs*

The American Medical Association reports that regional medical programs now exhibit good progress in these early stages but asks that Congress order an early evaluation by a non-government agency.

The AMA position was outlined by Bland W. Cannon, M.D. of the Association's Council on Medical Education, in testimony before the Subcommittee on Public Health and Welfare. The subcommittee is now considering legislation to extend the regional medical program law for five years.

Subcommittee members reacted favorably to an AMA recommendation that the extension be for only three years. Some of the congressmen also indicated opposition to a recommendation by Michael DeBakey, M.D., of Houston, Texas, that appropriations for the regional medical programs be increased sharply.

"We view with favor the early progress of RMP, its ability to build on existing patterns of medical care (sometimes adding new features or changing old ones as local demands and resources make possible) and the local flexibility which allows the program to make a real contribution to the health care of our nation," Dr. Cannon said. "At the same time, we recognize that the concept of the Regional Medical Program is still in its early stages of existence and that it is difficult fully to appraise the program. We do not know, for example, how much this program adds to the stress on an already overtaxed supply of available medical manpower. We also fear that the proliferation of federal health programs substantially contributes to the rise in health care costs. For this reason, we are pleased that H.R. 15758 provides for an evaluation of the program. We would suggest, however, that the evaluation begin July 1, 1968, rather than July 1, 1969, since 'evaluation' should be an integral part of the planning. We also suggest that the subcommittee consider further amending section 102 to provide that the evaluation shall be made by a non-government agency. . . .

"We recommend that the subcommittee delete the open-end authorization for funds for the four fiscal years ending after June 30, 1969. Since we are dealing with a relatively untried program, we believe it would be wise to limit the authorization to such sums as this subcommittee may determine to be reasonable, rather than to provide for 'such sums as may be necessary for the next four fiscal years.' "

Henry Brill, M.D. of Brentwood, N.Y., chairman of the AMA's Committee on Alcoholism and Drug Dependence, said that the AMA supported the part of the legislation authorizing federal grants for construction of facilities for a new program for alcoholic and narcotic addict rehabilitation. "However," he said, "we have long felt that funds for staffing and operation are properly the responsibility of the community, once the major burden of construction has been met with federal assistance."

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* See Page 257, this issue — Progress report for New Jersey, prepared by the Acting Director and Assistant Acting Director, New Jersey Regional Medical Program.

1968 Golden Merit Awards

Following are the remarks of retiring President Louis K. Collins on the occasion of the Twelth Annual Bestowal of the Golden Merit Awards at the 202nd Annual Meeting of The Medical Society of New Jersey on May 18.

Today one of the most pleasurable events during my term of office takes place — the awarding of these Golden Merit Award plaques to 42 graduates of 27 different medical schools of the class of 1918. That surely must have been a trying time in the midst of the effects of World War I.

We are now once again in a precarious situation, not only in Vietnam, but also in our medical manpower shortage. I don't know how many of you are retired or plan to retire soon, but just because you have reached this 50 year milestone is no real reason to take to the old rocking chair entirely. You appear to be spry and able, and if you each practiced medicine just one or two days a week, think how many full-time physicians you would be the equivalent of.

We are trying to stimulate inactive nurses and other ancillary personnel to return to part or full-time duty, and we provide refresher courses for this purpose. Imagine the great potential you and others in similar situations offer today. The country and its people need practitioners of your mature knowledge and experience, now more than ever. Please think it over. In 16 years I am looking forward to semi-retirement on the golf course, if I can still swing a club; but I'll have to work part time to pay my 50-cent Nassau losses.

I am reminded of two incidents — one recent and the other thirty-five years ago — that have bearing upon my previous statements. While attending the annual meeting of the Medical Society of the State of New York this past February, Jefferson Medical College (my Alma Mater) held a reception in New York City. As my wife and I were enjoying reminiscing with old and new acquaintances, an elderly gentleman, carrying a cane, entered the room. Conversation revealed that he was the author of that "best seller" of the 1930's, *An American Doctor's Odyssey*. Dr. Victor Heiser was graduated from Jefferson Medical College not 50 years ago, not 60 years ago, but 71 years ago — in 1897. He was not only keen of mind and spirit, but after the affair, walked alone three blocks to his apartment in the bitter cold wind. Dr. Heiser is 95 years young. Last month he was awarded the Alumni Achievement Award by Jefferson.

The other incident, also involving my Alma Mater, Jefferson, took place in the spring of 1933. As we "juniors" gathered in the non-air conditioned "pit" to hear Dr. E. Quin Thornton lecture on therapeutics, an astounding phenomenon took place. "Pappy" Thornton, as many of you will remember, was dressed as usual in his cutaway, with striped trousers and high collared shirt. He paused and calmly began to disrobe. Off came the jacket, trousers, and shirt to reveal a sweater and plus fours beneath. Dr. Thornton, then in his 80's was prepared for a round of golf.

Friends, we need your wisdom and counsel in this electronic age. Your patients need your soothing voice and gentle touch.

In the name of all your colleagues, I offer sincere congratulations and best wishes for continued good health, and a happy future. As Robert Louis Stevenson wrote, "You are the flower of our civilization, such as it is." Gentlemen, farewell and God bless you all.

RECIPIENTS OF THE GOLDEN MERIT AWARD OF THE MEDICAL SOCIETY OF NEW JERSEY

ATLANTIC COUNTY

James Henry Mason, III, M.D., 500 Fourth Ave., Absecon 08201
Daniel Cooper Reyner, M.D., 311 North Douglas Ave., Margate 08402
Sidney Rosenblatt, M.D., 1904 Pacific Ave., Atlantic City 08401
George Charles Schwarzkopf, M.D., 5900 Atlantic Ave., Ventnor 08406

BERGEN COUNTY

William John Greenfield, M.D., 50 Anderson St., Hackensack 07601

BURLINGTON COUNTY

Joseph Matthew Kuder, M.D., 104 Garden St., Mount Holly 08060
Samuel Emlen Stokes, M.D., 150 Schooley St., Moorestown 08057

CAMDEN COUNTY

William A. H. Scheffler, M.D., 23 East Maple Ave., Merchantville 08109
Benjamin M. Wroblewski, M.D., 1166 Thurman St., Camden 08104

CUMBERLAND COUNTY

Horace Jacques Ettinger, M.D., 200 North East Ave., Vineland 08360

ESSEX COUNTY

Nicholas V. Del Deo, M.D., 170 Bloomfield Ave., Newark 07104
Haynes Harold Fellows, M.D., 841 Audubon Lane, Winter Park, Florida 32789
Toufick Nicola, M.D., 96 Gates Ave., Montclair 07042
John N. Pannullo, M.D., 365 Roseville Ave., Newark 07107
Abraham Louis Reich, M.D., 109 South Munn Ave., East Orange 07018
Ralph Harrison Salsberg, M.D., 2130 Millburn Ave., Maplewood 07040
Samuel Schulsinger, M.D., 80 Clinton Ave., Newark 07114
Paul Slavin, M.D., 31 Lincoln Park, Newark 07102
Elmer William Smalzried, M.D., 9161 Mercedes Circle, Garden Grove, California 92641
Leo Michael Strauss, M.D., 44 South Munn Ave., East Orange 07018
Mykola Terlecky, M.D., 719 South 18th St., Newark 07103
John Wagner, M.D., 48 Wilson Ave., Newark 07105
Irving Willner, M.D., 49 Collinwood Road, Maplewood 07040

HUDSON COUNTY

Samuel Selinger, M.D., 109 Sixth St., Hackettstown 07840
William Levett Yeaton, M.D., R.D. 2, Box 494, Newton 07860

MERCER COUNTY

Johannes F. Pessel, M.D., 224 West State St., Trenton 08608
Ernest Francis Purcell, M.D., 800 Stuyvesant Ave., Trenton 08618
Paul Bryson Reisinger, M.D., 855 Berkeley Ave., Trenton 08618
Jeems Brutus Spradley, M.D., 777 West State St., Trenton 08618
Stephen Vaczi, M.D., 983 South Broad St., Trenton, 08611

MIDDLESEX COUNTY

Edward Hurtado, M.D., 155 East Chestnut Ave., Metuchen 08840
William London, M.D., 255 State St., Perth Amboy 08861

MONMOUTH COUNTY

Robert Henry Stockfisch, M.D., 255 Third Ave., Long Branch 07740

PASSAIC COUNTY

J. Vernon Hughes, M.D., P.O. Box 454, Passaic 07055
Abraham Kovin, M.D., 123 Lexington Ave., Passaic 07055
Sandor A. Levinsohn, M.D., 656 East 29th St., Paterson 07504
Dominick Marini, M.D., 40 Henry St., Passaic 07055
Joseph Francis Anthony RuBacky, M.D., 61 Passaic Ave., Passaic 07055

SOMERSET COUNTY

Theodore M. Silverman, M.D., 272 Lakeview Avenue, Paterson 07503

UNION COUNTY

William Burnside Fort, M.D., 2001 N.E. 30th St., Pompano, Florida 33064
Robert Sylvester Milligan, M.D., 42 Elm St, Summit 07901
Stephen Andrew Steele, M.D., Lost River Road, North Woodstock, New Hampshire 03262

Diagnostic Center—Menlo Park

The Diagnostic Center provides psychiatric evaluation for socially disordered individuals. The criterion of acceptance is (1) a problem in psychiatric diagnosis and (2) manifestation of this problem by some type of anti-social behavior. Persons of both sexes may be evaluated whether or not they are convicted offenders. Primary focus is, however, on the juvenile delinquent and the criminal. In practice, court referrals receive priority.

Residential facilities are reserved for boys and girls between the ages of 8 and 18. Bed capacity is 76. Maximum length of stay, fixed by statute, is 90 days. A limited number of private referrals are accepted. Court referrals however, must be given priority.

Procedure for private admission:

(1) The problems exhibited must meet the criteria mentioned above.

(2) Some outside agency or private physician must act as a referring agent to whom the evaluation report would be sent and who would implement the recommendations.

(3) Following receipt of the letter of referral an interview will be scheduled with the parents.

(4) When a child is admitted on a private basis, the family or referring agent becomes responsible for payment of the fee which is $22 the first day and $7 per day thereafter.

Examination of convicted sex offenders is strictly limited to an *outpatient basis.* Outpatient service is limited to Court and agency referrals. *No private patients are admitted for outpatient service.* Except that there is no age limit, the outpatient criteria parallel that of the inpatient service.

As is true in the inpatient service, the evaluation report is forwarded to the referring authority containing diagnostic conclusions and recommendations.

Ralph Brancale, M.D.
Medical Director

Doctors For Legalizing LSD, Keeping Troops In Vietnam, Nominating Richard Nixon

Although the Federal Government now bans the manufacture, distribution, and sale of LSD, four out of five physicians are opposed to this ban. So it appears from the monthly national physicians' opinion poll (called *Playback*) conducted in March 1968 by Marion Laboratories Inc. Two thirds of physicians believe that the ban should be lifted to allow LSD to be used for "limited" research. An additional 14 per cent of the doctors believe that LSD should be made generally available for clinical research.

On the utilization of a new type of Physician's Assistant, three out of four physician respondents indicated that they *would* employ such an assistant in their private practice. But, the use of such additional trained aides might be limited. Only 35 per cent of the respondents said they would find great use for physician's assistants, and 40 per cent said they would find little use. One of four doctors said they would have no use for physician's assistants.

Concerning Viet Nam, physicians were asked their opinions on approval or disapproval of:

1. Complete withdrawal of U.S. and allied tropps.

2. Use of tactical nuclear weapons, "if this would help bring the war to a quicker and more positive conclusion."

Withdrawal of troops was opposed by 68 per cent of the physician respondents, supported by 30 per cent, with only 2 per cent undecided. Use of tactical nuclear weapons was supported by 49 per cent of the respondents and opposed by 46 per cent, with 5 per cent undecided. Among the medical specialties, strongest support for use of such weapons came from the general practitioners, with 55 per cent of these respondents answering in the affirmative. Strongest opposition came from the cardiologists, with 65 per cent opposing A-weapon use.

The predominantly Republican physician respondents gave strong support to Nixon in a straw vote runoff with Rockefeller and Reagan. Nixon won the vote of 55 per cent of the physicians, Rockefeller 29 per cent and Reagan 16 per cent. These results closely follow those obtained in a recent Gallup poll of the general population which showed 49-22-11 per cent respectively.

Family Doctors Training at Hershey

In the April 1968 issue of this JOURNAL (p. 135), we commented favorably on Vanderbilt University's Medical School program for training students in family medicine. We have just heard from George T. Harrell, M.D., dean of the Hershey Medical Center (Pennsylvania State University), calling attention to the fact that this school also has such a program. Dr. Harrell wrote an article on this which was published in the February 12, 1968 issue of *The Journal* of the American Medical Association (203:495), to which our readers are referred. Indeed, a unique Department of Family and Community Medicine is an integral part of this new medical school.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

DERMATOLOGY—Robert J. Carnathan, M.D., 1043 Fernwood Avenue, Maple Shade, New Jersey 08052. Georgetown 1962. Association with dermatologist, or multispecialty group. Available July 1968.

GENERAL—Loren T. Burns, M.D., 7 West 14th Street, New York 10011. University of Illinois, 1967. Available July 1968.

INTERNAL MEDICINE—Harvey I. Hurwitz, M.D., 33 Coleman Road, West Haven, Connecticut 06516. Boston University, 1962. Group. Available July 1968.

Alfred M. Derrow, M.D., 555 Wisteria Way, San Rafael, California 94903. Tufts 1962. Subspecialty, Renal Disease. Group. Available July 1968.

Seymour M. Cohen, M.D., 1565-A White Drive, Rantour, Illinois 61866. University of Pittsburgh, 1962. Board eligible. Subspecialty, Hematology. Group or partnership. Available July 1968.

George G. Shashaty, M.D., 287 Linden Boulevard, Brooklyn, New York 11226 Georgetown University, 1962. Subspecialty, Hematology. Group or partnership. Available July 1968.

Harry M. Friedland, M.D., 2329 South Cedarbrook Road, Springfield, Missouri 65804. Downstate Medical Center (NYU), 1961. Subspecialty, Gastroenterology. Available July 1968.

Richard Kroner, M.D., 3750 Hudson Manor Terrace, Riverdale, New York 10463. New York Medical, 1964. Group. Available July 1968.

Edgar Lichstein, M.D., 1777-F Arlin Village Place, Fairborn, Ohio 45324. Downstate Medical Center (NYU), 1961. Board eligible Subspecialty, cardiology. Available July 1968.

Allan M. Sulzer, M.D., APO New York 09254, Tuslog Det. 37. University of Pittsburgh, 1964. Locum Tenens — November 1968-June 1969.

Irving Schiffman, M.D., 2025 A Werner Park, Fort Campbell, Kentucky 42223. Downstate Medical Center 1959. Board Certified. Subspecialty, Cardiology. Group or partnership. Available August 1968.

Raymond L. Hargrove, M.D., 44 Norman Place, Box 113, Tenafly, New Jersey. University of Pennsylvania, 1961. Board eligible. Subspecialty, gastroenterology. Group. Available July 1969.

OBSTETRICS AND GYNECOLOGY—Kenneth E. Bell, M.D., 3175 B Lexington Street, Hill Air Force Base, Utah 84401. University of Buffalo, 1961. Board certified. Available June 1968.

Jerry Goosenberg, M.D., 75-B Yorktown Drive, Fort Lee, Virginia 23801. Jefferson, 1962. Board certified. Group. Available July 1968.

Arnold J. Halpern, M.D., 516 Almond Court, Hampton, Virginia 23369. Jefferson, 1959. Board certified. Available June 1968.

Nicholas J. Criares, M.D., 8121-D Colorado Street, Wurtsmith A.F.B., Michigan 48753. St. Louis University, 1960. Board eligible. Group or associate. Available July 1968.

Lawrence N. Margolies, M.D., 12510A Turner Circle, Omaha, Nebraska 68123. Columbia 1962. Board eligible. Available July 1968.

PATHOLOGY—Irvin D. Bough, M.D., 350 Lenox Road, Brooklyn, New York 11226. University of Santo Tomas, Manila, 1959. Board certified. Hospital. Available.

PEDIATRICS — James Sorger, M.D., 27 Warner Arms, Warner Robins, Georgia 31093, NYU Medical, 1963. Board eligible. Solo, group, partnership, or association. Available July 1968.

SURGERY—Dennis M. Wadler, M.D., 245 East 25th Street, New York 10010. Jefferson, 1961. Board eligible. Associate or group. Available July 1968.

Morton H. Goldstein, M.D., 3411 Wayne Avenue, Bronx, New York 10467. University of Chicago, 1959. Board certified. Plastic. Available summer 1968.

Martin Winick, M.D., 800 Victory Boulevard, Staten Island, New York, Downstate Medical Center (NYU), 1960. Board certified. Pediatric. Available July 1968.

Donald A. Sugar, M.D., 5 Wheeler Place, Fort Stewart, Georgia 31313. New York Medical, 1961. Board — part I. Group or solo. Available May 1968.

Robert Wegryn, M.D. St. Mary's Hospital, 89 Genesee Street, Rochester, New York 14611. Cornell, 1963. Board qualified. Group or partnership. Available August 1968.

UROLOGY—Alessandro Colalillo, M.D., 570 Mt. Prospect Avenue, Newark, New Jersey. University of Naples, Italy, 1955. Partnership or association with multispecialty group. Available.

Raymond D. Panetta, M.D., 632 Massachusetts Avenue, Riverside, California 92507. Georgetown, 1959. Board eligible. Group, partnership, or solo. Available June 1968.

Stanley W. Gensler, M.D., 3rd Surgical Hospital, Dangtam, Vietnam, APO 96372. Albert Einstein, 1961. Board certified. Partnership or group. Available July 1968.

ANNOUNCEMENTS

Course In Electronic Instrumentation

A summer course — running only three weeks — is now available to physicians interested in electronic instrumentation. The $450 tuition fee covers books, luncheons, and laboratory fees. The program starts on July 20 and terminates on August 10, 1968. The course is given at the Polytechnic Institute in Brooklyn, and inquiries should be directed to Kenneth R. Jolls, Polytechnic Institute, 333 Jay Street, Brooklyn, New York 11201.

Occupational Health For Nurses

From November 11 to November 15, 1968, New York University will offer a full-time, five-day course in occupational health. Tuition is $150. Subjects to be covered include: the objectives and scope of an occupational health program, the relationship between doctor and nurse, and employee. Special emphasis is given to interviewing and counseling, and the role of the nurse in psychiatric problems. Environmental hazards, retirement and the problems of the older workers, legal aspects of medicine and nursing in an occupational health service, and legal aspects of workmen's compensation are covered. Applications should be sent to the Recorder, New York University Post-Graduate Medical School, 550 First Avenue, New York 10016.

Caribbean Cancer Congress

Now is the time to make reservations for the Caribbean Cancer Congress in Kingston, Jamaica, November 24 to November 27. Travel arrangements are made through the Travel Service of the First National City Bank at 399 Park Avenue, New York City 10022.

Purpose of the Congress is to review contemporary methods of diagnosis and treatment of cancer and to evaluate research in this field. Guest lecturers of international repute will participate, as well as doctors practicing in the Caribbean and Latin American Countries.

Apart from the scientific value, you will be afforded the warm hospitality, sunshine, and scenery of the Island of Jamaica.

Details about the scientific program, which will be held at the University Hospital in Kingston, or requests to give papers, should be sent to Kenneth A. McNeill, M.D., Caribbean Cancer Congress, 5 Tangerine Place, Kingston 10, Jamaica, West Indies.

Degree Program Trains Physicians For Electronic Era

The College of Engineering of Rutgers — The State University — has established a unique, experimental program to train physicians for the electronic world of medicine. This is the result of an association between Dr. Walter Welkowitz, professor of Biomedical Engineering at the University, and Dr. Hugo Pribor, director of the Institute of Laboratory Medicine, Perth Amboy General Hospital (see article p. 249 of this issue).

The course, which will begin in September, offers sufficient engineering background so that physicians can pursue studies leading to a masters' degree in biomedical engineering. The complete program will be outlined in the August issue of this JOURNAL. Those interested should write to Dr. Walter Welkowitz, Department of Electrical Engineering, Rutgers — The State University, New Brunswick, New Jersey.

Graduate Ophthalmology Courses

The Eye and Ear Infirmary in New York announces a series of graduate courses in ophthalmology from September 4th through December 4th, 1968. For details, write to Postgraduate Institute, Eye and Ear Infirmary, 310 East 14th Street, New York 10003.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1968

June

10-14 and 17-21 **Atlantic City Hospital**
Atlantic City
Visiting Chief Program

11 **Ocean County Medical Society**

11 **Bergen County Medical Society**

11 **Cumberland County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"The Thymus — Its Role in Immunity and Disease"

12 **The Academy of Medicine of New Jersey — Section on Psychiatry and Neurology and the New Jersey Association of Social Workers, Northern and Southern Chapters**
The Mountainside Hospital
Montclair
"Psychological Therapy and/or Case Workers"

18 **Warren County Medical Society**

20 **Morris County Medical Society**

20 **The Academy of Medicine of New Jersey and the New Jersey State Health Department**
Somerset Hospital
Somerville
Symposium: "Acute and Chronic Care of Alcoholics"

September

24 **Hunterdon County Medical Society**

October

9 **Essex County Medical Society**
Dinner Meeting with Auxiliary
"Sex Education in the Schools"

November

13 **The Academy of Medicine of New Jersey**
The Mountainside Hospital
Montclair
Symposium: "Evaluation and Maintenance of a Favorable Fetal Environment"

13 **American College of Physicians New Jersey Regional Meeting**
Rutgers University Medical School
New Brunswick

14 **Essex County Medical Society**

20 **New Jersey State Dental Society**
Semi-Annual Session

26 **Hunterdon County Medical Society**

December

11 **Academy of Medicine of New Jersey**
Cherry Hill Inn
Symposium: "Treatment of the Accident Victim"

1969

January

28 **Hunterdon County Medical Society**

February

19 **Academy of Medicine of New Jersey**
Symposium: "What's New in Cancer"

New Jersey Doctor To AMA Rating Committee

Henry H. Kessler, M.D. of Newark has just been reappointed to the AMA Committee on Rating of Mental and Physical Impairment. This Committee is developing a series of practical guides to assist physicians in evaluating permanent impairment. Each guide is prepared by distinguished specialists in the area of the body concerned.

OBITUARIES

Dr. Robert Eisenhauer

At the untimely age of 42, Dr. Robert Eisenhauer died on April 11, 1968. A 1950 graduate of the medical school of the University of Pennsylvania, he became a board-certified ophthalmologist and was on the staff of the Englewood Hospital. He was active in the affairs of the American Academy of Ophthalmology and Otology, and in committee work for our Bergen County Medical Society.

Dr. George E. Randall

George E. Randall, M.D., a busy family doctor in Bergen County, died on March 2, 1968, at the age of 54. Dr. Randall, though he always proudly called himself a general practitioner, was much interested and skilled in orthopedics. He was on the staff of the Valley Hospital in Ridgewood. Dr. Randall received his M.D. at Temple University in 1942.

Dr. Nicholas P. Reale

The Peter Bent Brigham Hosptal in Boston was the scene on April 7, 1968, of the death of Nicholas Reale, M.D. He was only 62 years old at the time of his death. Dr. Reale was born in Newark in 1906. He received his baccalaureate degree at Rutgers in 1928 and his M.D. at Long Island in 1932. He was a general surgeon with special interests and skills in gynecology and obstetrics. He served New Brunswick, his adopted city, and Manville, his later residence, as school surgeon, township physician, and as a member of the Manville Board of Education. Dr. Reale was on the staff of St. Peter's Hospital in New Brunswick.

Dr. Benedict B. Scassera

An active Mercer County general practitioner, Benedict B. Scassera died on February 18, 1968. Dr. Scassera was on the staff of the Princeton Hospital, was concerned in civic affairs of the borough of Princeton, and was involved in organizational affairs in the Mercer County Medical component of The Medical Society of New Jersey. He was a graduate of the medical school of Georgetown University in the class of 1931.

Dr. Ralph B. Thomas

One of Monmouth County's senior medical practitioners died on March 2, 1968, with the passing that day of Ralph B. Thomas, M.D. of Eatontown. A 1909 alumnus of the medical school of the University of Vermont, Dr. Thomas was a general practitioner, especially interested in industrial surgery, and otology and ophthalmology. At the time of his death, he had reached the grand age of 81.

BOOK REVIEWS

The Psychiatric Consultation. W. M. Mendel, M.D. and Philip Solomon, M.D. New York, 1968, Grune and Stratton. Pp. 219. ($9.75)

"While formerly," say the authors in their preface, "the psychiatrist was responsible for the treatment of patients, he is now viewed as the leader of a mental health team." Thus, we are moving toward the ultimate psychiatrist, the one who never sees patients but tells other people how to handle them. For those aiming in that direction, here indeed is a survival kit. We are told for example, how to consult with clergymen, with Judges, with general medical practitioners, with college administrative officials, with government officials, with personnel people in industry, with public schoolmen, and with our own residents and trainees.

The 18 chapters are by as many authors. Included is a sweeping overview of all the chapters by the junior editor.

It is always a question as to whether one can be taught how to be a consultant. Some of the authors imply that reacting to a consultation request is a sort of art or mystique, while others suggest that it is a teachable science. The text here includes practical suggestions on the teaching of the art of consultation. The chapters are short, the material is well organized, and the coverage is in depth. The book must be unique in its field and makes one wonder why no one ever thought of this before. ABRAHAM LEFF, M.D.

Treatment Of Heart Disease In The Adult. Ira L. Rubin, M.D., Harry Gross, M.D., and Sidney R. Arbeit, M.D. Philadelphia, 1968, Lea and Febiger. Pp. 393. Illustrations 123. ($17.50)

During recent years, many books have been written on every phase of heart disease. Here, however, is not just another book for the library or for the doctor's shelf. It is a carefully written text on how to treat the adult with heart disease — who may be subject to many complications and emergencies. Progress in the therapy of the cardiac has been so rapid in the past two decades, with new and radical treatment, that the authors were prompted to write this book.

Although the title of the book is "treatment," there is good coverage of the etiology, symptomatology, physiology, and pathology.

The first chapter is devoted to coronary heart disease, since it is the leading cause of death — and the leading cause of disability among middle aged men. The major complication, acute myocardial infarction, is covered in detail including the therapy of shock and every complication which may occur in this common cardiovascular condition. The appendix to the chapter outlines the routine orders for the treatment of uncomplicated as well as complicated cases. There is even a useful outline of instructions to the patient for care at home, after discharge from the hospital.

The following chapter deals with drugs used in the management of coronary heart disease. It is up-to-date, including the pharmacology of such new drugs as Propanolol® (a beta adrenergic blocking agent). Next we have an excellent chapter on the treatment of the cardiac arrhythmias, with illustrative electrocardiograms of the common irregularities. The use of cardiac pacemakers, both temporary and permanent, is discussed as is the technic of synchronized D.C. electric shock for the conversion of arrhythmias.

At the end of each chapter, is a useful list of "recommended reading." The volume includes 18 chapters, each meticulously presented, including such topics as surgical therapy, pregnancy and heart disease, with an excellent chapter on rehabilitation of the cardiac patient.

I enjoyed reading and reviewing this book, and recommend it to all physicians who come in contact with the treatment of cardiovascular patients, whether they be internists, cardiologists, or general practitioners. In fact, a copy of this book should be made available to the house staff in each hospital. The use of this text will be of great aid in the treatment of cardiovascular patients.

Treatment of Heart Disease in the Adult has been well prepared, the print is easy to read, and the illustrations are excellent. JEROME G. KAUFMAN, M.D.

Physical Standards in World War II. Editor-in-Chief Robert S. Anderson, M.D. Washington, D.C., 1967, Department of the Army. Pp. 356. ($3.00)

This volume opens with a brief history of military physical standards from Gideon selecting from among more than 30,000 men the 300 who defeated a vastly larger force of Midianites, and then the text traces the story up to the time of World War II.

The major section of the book is on problems of devising and administering regulations concerning physical standards. The press of mobilizing 10 million men uncovered unforeseen difficulties. Constantly greater manpower requirements meant lower entrance requirements. Makeshift policies for utilizing limited service personnel fluctuated greatly, but the greatest problem with the standards was with those devised to exclude the mentally defective. Mental defects accounted for 30 per cent of all those rejected, but this diagnosis was responsible for 45 per cent of all discharges for disability.

Details of regulations concerning physical standards plus a tabular summary of the changing standards of acceptability through the war are included in appendices. This volume will be of value to anyone concerned with setting physical standards for any set of circumstances. It will be of historical interest, to those who played some role in wartime medicine.

HYMAN W. FISHER, M.D.

The Balkan Nephropathy. Ciba Study Group #30. Editored by G. E. W. Wolstenholme and Julie Knight. Boston, 1968, Little, Brown. Pp. 125. Illustrations 29. ($3.50).

This small volume reports on a conference held last year (1967) under the auspices of The Ciba Foundation in London, England. Participants were scientists from various European medical schools.

Balkan Nephropathy is found in Rumania, Bulgaria, and Yugoslavia. Most cases occurred in patients between 30 and 60 years of age. First manifestations are lassitude, fatigue, poor appetite, sallowness and (occasionally) dull sacral backache. Specific findings include a sallow copper colored skin, frequent xanthodermia of palms and soles, anemia (even in the preazotemia stage and insignificant albuminuria. There is no hypertension nor edema. Tubular and interstitial alterations precede glomerular changes and result in markedly contracted kidneys. Attempts to relate this nephrophy to an infectious or toxic element have so far been unsuccessful. Part of this symposium is devoted to a discussion of the urinary protein excretion in this nephropathy.

While this volume may have some value for Physicians with a special interest in renal disease, it cannot be recommended for general use because of its limited scope in dealing with so rare and localized a clinical entity. EDWIN KELLERMAN, M.D.

Communication in Science. Edited by Anthony de-Reuck and Julie Knight. (Pp. 274). Boston 1968. Little Brown ($12.50)

In November 1966, the Ciba Foundation hosted a colloquium on documentation, automation, and other aspects of communication in science. Some two dozen specialists explored the efforts now being made to tame the wild information explosion which is inflating our libraries to apparently irretrievable proportions. Satellites to transmit ideas? Computers? International networks? Special information services? How can we reduce all this to manageable size? The problem now is not storage but retrieval. Most of us can remember the days when 25 cents to the AMA package library would bring you a packet of reprints on any medical topic and you could use that as your base in writing a new article. Those days are gone forever.

So, if you don't mind the relatively high price ($12.50 for a 274 page book) you will find here a thought-stimulating text on this problem. If at times it sounds like Buck Rogers in the 21st century, do not worry. We'll catch up to Buck Rogers yet — and here is one of the road maps. WILLIAM SCHRAM, M.D.

Heredity, Disease, And Man: Genetics In Medicine. Alan E. H. Emery, M.D. Berkeley, California, 1968, University of Cailfornia Press. Pp. 247. Illustrations. ($6.95)

"Because of advances in medicine and surgery, diseases due to infections and nutritional deficiencies are gradually being controlled. Environmental diseases are being displaced by others which are largely or even entirely genetically determined. The result has been a change in the sort of problem the physician encounters in his pediatric practice. Congenital abnormalities and hereditary disorders are becoming of increasing importance and the physician is being asked more and more often to given advise concerning genetic problems. Such problems may involve the advisability of cousin marriages, delayed or abnormal sexual development, recurrent abortion, child adoption, paternity determination, and particularly the risks of recurrence on certain hereditary disease."

The above introduction to one of the chapters in this interesting book is the prime reason it should be in the library of family physicians, pediatricians, and internists.

Genetic factors are discussed in such common diseases as diabetis mellitus, peptic ulcer, hypertension, phenylketonuria, mongolism, and cancer. Also reviewed is the subject of radiation and heredity. This is studied against the background of the 1945 Hiroshima incident and its effect on subsequent generations.

Tomorrow's physician may become more involved in treating people who appear perfectly healthy but are genetically predisposed to a particular disease. He may even find himself treating mothers during pregnancy with the hope of preventing certain hereditary diseases in their offspring. Medical genetics may well become the preventive medicine of the future.

Dr. Emery has made an excellent contribution to the subject by this short and easily read summary of human genetics. He has described some of the advances and applications being made in clinical medicine. Case histories are given in a brief form, references are given at the end of each chapter and a clear glossary of terminology appears at the end of the book.

HARRY M. POPPICK, M.D.

The Future of the Computer Utility. Compiled by C. C. Barnett, Jr. and associates for the American Management Association. Published by the Association at 135 West 50th Street, New York 10020 New York, pp. 158 ($9.00).

This book presents a non-technical report of on-line computer-sharing services. The book provides a well written and comprehensive summary for anyone considering the use of time-sharing services because it presents what is probably a fairly accurate forecast of time-sharing service bureaus or "Computer Utilities." The usual program includes a time-shared computer connected through a communications network to remote users who interact with the computer through a keyboard terminal device. Such a system offers access to a large, versatile computer but you pay only for the computer time you use plus the communications line and terminal charges.

The future of the computer utility concept will depend upon the markets which the utility companies can successfully cultivate. A prime example has been the problems encountered with doctor's billing services: no two localities are satisfied with the same program, so continual modifications must be made if the utility wishes to expand its operation. The type of utility which offers the greatest potential for making a go of it is the one which offers a common data base to many users for a variety of uses. Whether the users of a utility have a similar purpose or are able to share a common data base seems to be the most important single consideration.

E. C. FOERNZLER, PH.D.

Health Insurance For Mental Illness. Patricia Scheidemandle, Charles Kanno, and Raymond Glasscote. Washington, D.C., 1968, National Association for Mental and the American Psychiatric Association. (Paperback — $2.50)

The Blue Cross and, to some extent, Blue Shield have been giving psychiatrists the blues ever since the plans started. Discrimination against emotional illness has been obvious from the start. The carriers and their actuaries displayed considerable ingenuity in rationalizing this prejudice. A few psychiatric labels (homosexuality, narcotic addiction, alcoholism and others) suggest some kind of "immorality" that companies don't want to spend money on. Diagnoses are often so vague that almost any one can be squeezed into a "personality disorder" for nstance. You have to have either a cycloid or a schizoid personality, and in that sense, you — and every one — has a psychiatric "diagnosis." Some mental illness is "chronic" and with average stay in public mental hospitals exceeding the one year mark, coverage for psychiatric disorders might conceivably drain out the funds. And in most cases you can't prove the diagnosis by anything nice and objective like an x-ray or a laboratory test.

Here is a meticulous in-depth study of the insurance aspects of mental illness. While everything still doesn't come out roses, it is gratifying to see how much the picture has improved and how swiftly much of the old folklore has been exorcised. Over 80 per cent of Blue Cross subscribers now have some kind of coverage for emotional disorders; many commercial insurance companies admit (usually rather quietly) that they have not been bankrupted by psychotic and neurotic subscribers as they feared when they reluctantly granted this coverage. And even when the legal maximum hospital coverage by Blue Cross or by a commercial carrier was 21 to 30 days, the average length of hospitalization turned out to be under 15 days. In the offices of privately practicing psychiatrists, about a third of the patients had insurance that did coverage a large part of the doctor bills.

The book is well illustrated with 20 figures (mostly graphs) and 20 tabulations, so that we here have a solid reference work on the subject.

Of course we still have a long way to go before mental illness becomes as actuarially respectable as colitis, thyroid disease, or pregnancy. Too many employee group plans require that physicians' reports go to employers — which is, in some cases, an outrageous breach of privilege. Most private office visits (about two thirds, actually) are not covered at all. Individuals (as opposed to groups) find it difficult to get commercial coverage for out-of-hospital mental illness. The services of social workers, psychologists, occupational therapists, speech pathologists, and special teachers are almost uniformly excluded. And the coverage is often sharply limited either in hospital days or total dollars, reflecting a reprehensible discrimination against the emotionally sick.

But a glance at almost any of the graphs here shows a year-by-year rising curve of coverage. So we do make progress!

HENRY A. DAVIDSON, M.D.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

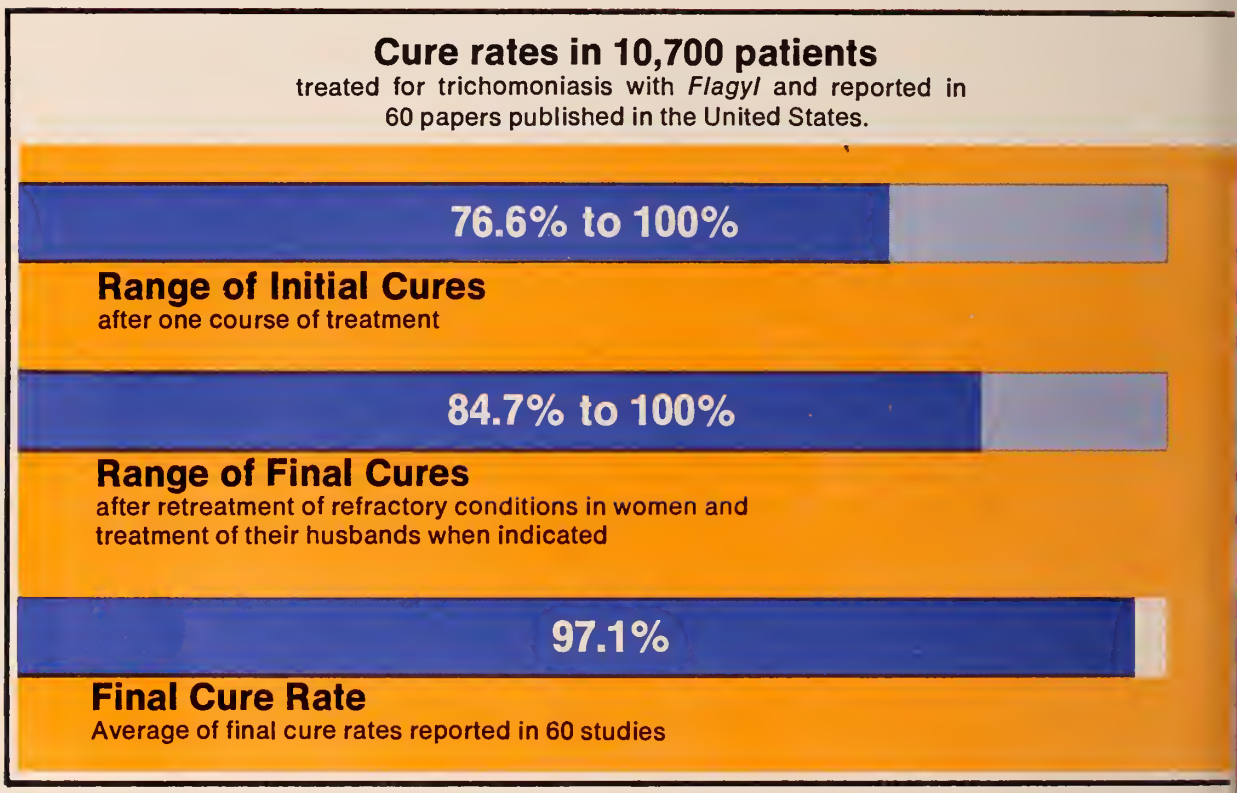
Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

True Drug Failure...

How often does it occur



Indications: Flagyl is indicated only in the treatment of trichomoniasis in both men and women.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects: Infrequent and minor side effects include nausea, metallic taste and furry tongu Gastrointestinal disturbances, flushing and hea ache sometimes occur, especially with concor itant ingestion of alcohol. The taste of alcohol beverages may be altered. Other effects, all r ported in an incidence of less than 1 per cent, a diarrhea, dizziness, vaginal dryness and burnin dry mouth, rash, urticaria, gastritis, drowsine insomnia, pruritus, sore tongue, darkened urir anorexia, vomiting, epigastric distress, dysuri depression, vertigo, incoordination, ataxia, a

...ith Flagyl®?

brand of

metronidazole

linical practice an occasional uncooperative or drug-sensitive patient pouse makes 100 per cent cure of trichomonal vaginitis in large series atients difficult.

Further a very few patients who apparently absorb Flagyl poorly a few rare instances of trichomonads resistant to Flagyl have been orted. Nevertheless, approximately half the United States investiga- report a final cure rate of 100 per cent with Flagyl.

Sixty papers[1] published on the use of Flagyl in trichomoniasis in the ted States and comprising a total of 10,700 patients have been evalu- l. In thirty of the papers it was declared that all patients adequately owed and treated were free of trichomonal infection.

Analysis of all of these papers shows that the incidence of cures for *initial* course of therapy ranged from 76.6 per cent to 100 per cent. cure rates after retreatment of female patients and treatment of their bands when indicated ranged from 84.7 to 100 per cent. The average l cure rate reported in all investigations was 97.1 per cent.

inal cramping, constipation, stomatitis, nbness or paresthesia of an extremity, joint s, confusion, irritability, weakness, cystitis, ic pressure, dyspareunia, fever, polyuria, in- tinence, decreased libido, nasal congestion, ctitis and pyuria. Elimination of trichomonads aggravate candidiasis.

age and Administration: In women: one -mg. oral tablet three times daily for ten days. aginal insert of 500 mg. is available for local apy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

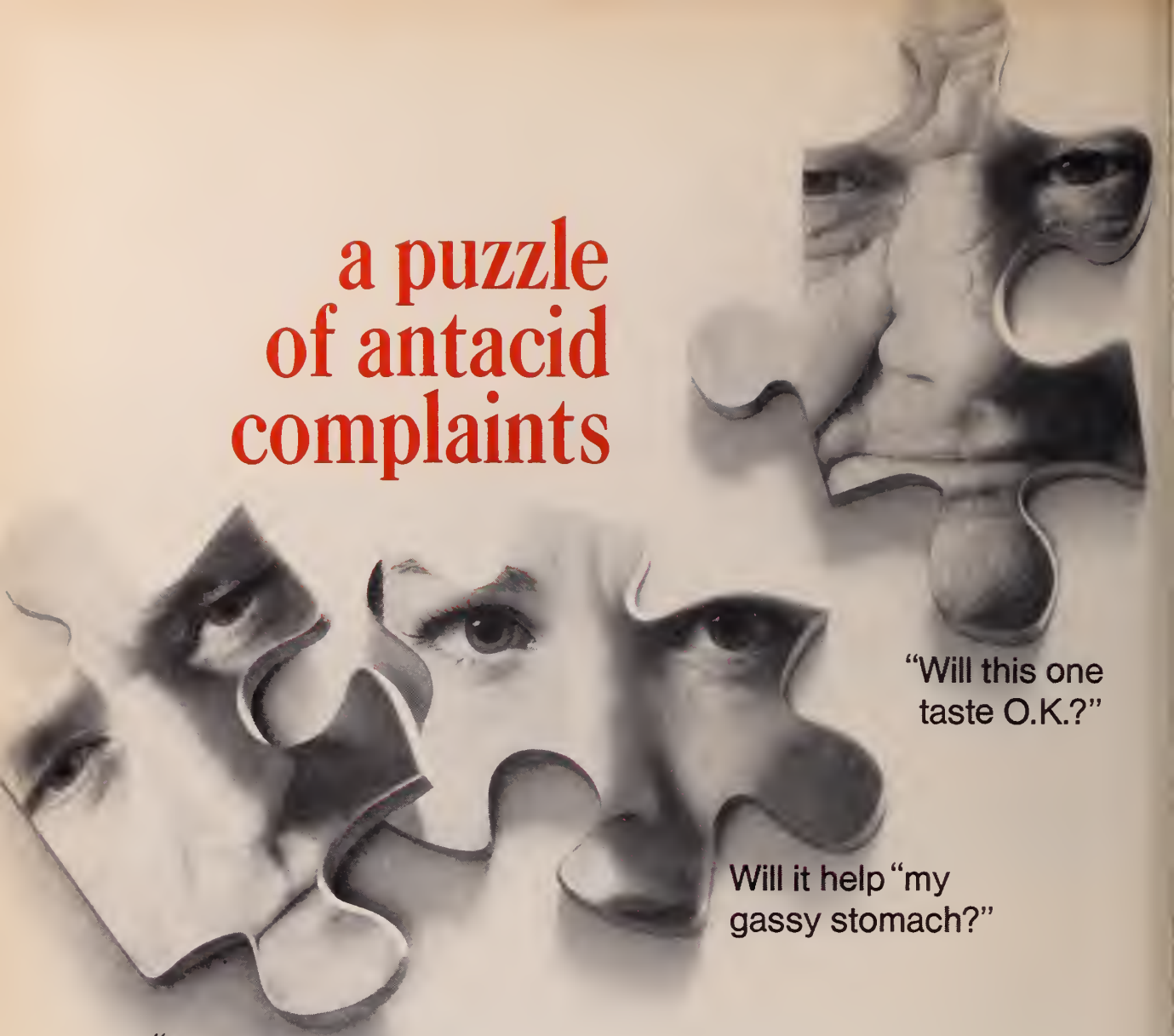
Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

1. Complete list of references on request.

SEARLE

Research in the Service of Medicine

a puzzle of antacid complaints



Mylanta®

aluminum and magnesium hydroxide *plus* simethicone

a solution to peptic ulcer distress

Effective neutralization—
with the two most widely prescribed antacids: aluminum and magnesium hydroxides.

Concomitant relief of G.I. gas distress—
with the proven[1] defoaming action of simethicone.

Prolonged acceptance confirmed—
in 87.5% of 104 patients after a total of 20,459 documented days of therapy.[2]

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg.
Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth) or one or two teaspoonfuls to be taken between meals and at bedtime.

References: 1. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966.
2. Danhof, I.E., Personal communication.

Stuart
Division/Pasadena, Calif.
ATLAS CHEMICAL INDUSTRIES, INC.

The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



ONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

ıe Ambar Extentab before breakfast can p control most patients' appetite for up 12 hours. Methamphetamine, the appe- suppressant, gently elevates mood and lps overcome dieting frustrations. Pheno- rbital, the sedative in Ambar, controls irritability and xiety...helps maintain a state of mental calm and equa- mity. Both work together to ease the tensions that erode willpower during periods of dieting.

so available: Ambar #1 Extentabs®—methamphetamine drochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warn- : may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220

A·H·ROBINS

Butazolidin® alka
in rheumatoid arthritis.

If it doesn't work in a week,
forget it.



ut don't forget this about Butazolidin alka

ontraindications: Edema; danger of cardiac ecompensation; history or symptoms of peptic lcer; renal, hepatic or cardiac damage; istory of drug allergy; history of blood dys-rasia. The drug should not be given when the atient is senile or when other potent drugs are iven concurrently. Large doses of Butazolidin lka are contraindicated in glaucoma.

Varning: If coumarin-type anticoagulants are iven simultaneously, watch for excessive ncrease in prothrombin time. Instances of evere bleeding have occurred. Persistent or evere dyspepsia may indicate peptic ulcer; erform upper gastrointestinal x-ray diagnostic ests if drug is continued. Pyrazole compounds ay potentiate the pharmacologic action of ulfonylurea, sulfonamide-type agents and nsulin. Carefully observe patients receiving uch therapy. Use with caution in the first tri-nester of pregnancy and in patients with yroid disease.

recautions: Before prescribing, carefully elect patients, avoiding those responsive to outine measures as well as contraindicated atients. Obtain a detailed history and a com-lete physical and laboratory examination, ncluding a blood count. The patient should not xceed recommended dosage, should be losely supervised and should be warned to iscontinue the drug and report immediately fever, sore throat, or mouth lesions (symp-oms of blood dyscrasia); sudden weight gain vater retention); skin reactions; black or tarry tools or other evidence of intestinal hemor-nage occur. Make complete blood counts at eekly intervals during early therapy and at -week intervals thereafter. Discontinue the rug immediately and institute counter-easures if the white count changes signifi-antly, granulocytes decrease, or immature rms appear. Use greater care in the elderly nd in hypertensives.

dverse Reactions: The more common are ausea and edema. Swelling of the ankles or ce may be minimized by withholding dietary alt, reduction in dosage or use of diuretics. In derly patients and in those with hypertension e drug should be discontinued with the ppearance of edema. The drug has been ssociated with peptic ulcer and may reac-tivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.



Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)46-070-A

r complete details, ease see full escribing Information.

Butazolidin® alka Geigy

Capsules
phenylbutazone, 100 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate, 150 mg.; homatropine methylbromide, 1.25 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

BU 5463 R



When they complain of edema from use of "the pill"

A percentage of women who take oral contraceptives will experience salt retention with resultant edema. This edema usually can be relieved by one of the diuretics. Consider the advantages of HYDROMOX* (Quinethazone). It has a prompt but gentle diuretic action. It usually brings about the desired effect on only one dose a day. The Na/K excretion ratio is relatively high (4.5-6.2:1)—which means the possibility of potassium depletion is reduced.

Hydromox* Tablets
Quinethazone

Precautions: Electrolyte abnormalities may be aggravated or produced. Caution is important during prolonged or intensive therapy and when salt intake is restricted. Hypokalemia has been mild and infrequent, and other electrolyte abnormalities rare. The possibility of potassium depletion and its toxic sequelae must be kept in mind, particularly in cirrhotics and patients receiving digitalis. As a preventive measure the use of foods rich in potassium, such as orange juice, may be desirable.

Although not a thiazide, HYDROMOX may possess certain characteristics of the thiazides. They have been known to cause jaundice with liver involvement and pancreatitis; hematological complications such as purpura with or without thrombocytopenia and leukopenia (neutropenia); increases of serum uric acid; decreased glucose tolerance as evidenced by hyperglycemia and glycosuria thus aggravating or provoking diabetes mellitus and azotemia in patients with renal disease; photoallergy. Discontinue use a few days prior to elective surgery. When added to a regimen that includes ganglionic-blocking agents, the dosage of these latter preparations should be reduced. Also reduce dosage when one or more of these antihypertensive agents is added to an established HYDROMOX regimen. Contraindicated in anuria. Observe for possible hematologic complications.

Side Effects: Skin rash; gastrointestinal disturbances (chiefly nausea), weakness, dizziness. These seldom require cessation of therapy, and can be relieved by reducing dosage or correcting electrolyte imbalance.

Warning: Enteric coated potassium tablets have been implicated in small bowel lesions and should be used only when adequate dietary supplementation is not practical.

*Reg. U.S. Pat. Off.

Lederle LEDERLE LABORATORIES • A Division of American Cyanamid Company, Pearl River, New York

388-8

"Prescribe With Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

Barefoot Freedom

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR FOR MEN - WOMEN - CHILDREN
OUTFLAIR SHOES FOR CLUB FEET

69 WESTWOOD AVENUE
WESTWOOD, N. J.

350 MAIN STREET
HACKENSACK, N. J.

Dennis Brown Splints — In all sizes — Carried in stock
CUSTOM SHOE SHOP ON PREMISES



Vacation trip....

Motion sickness?



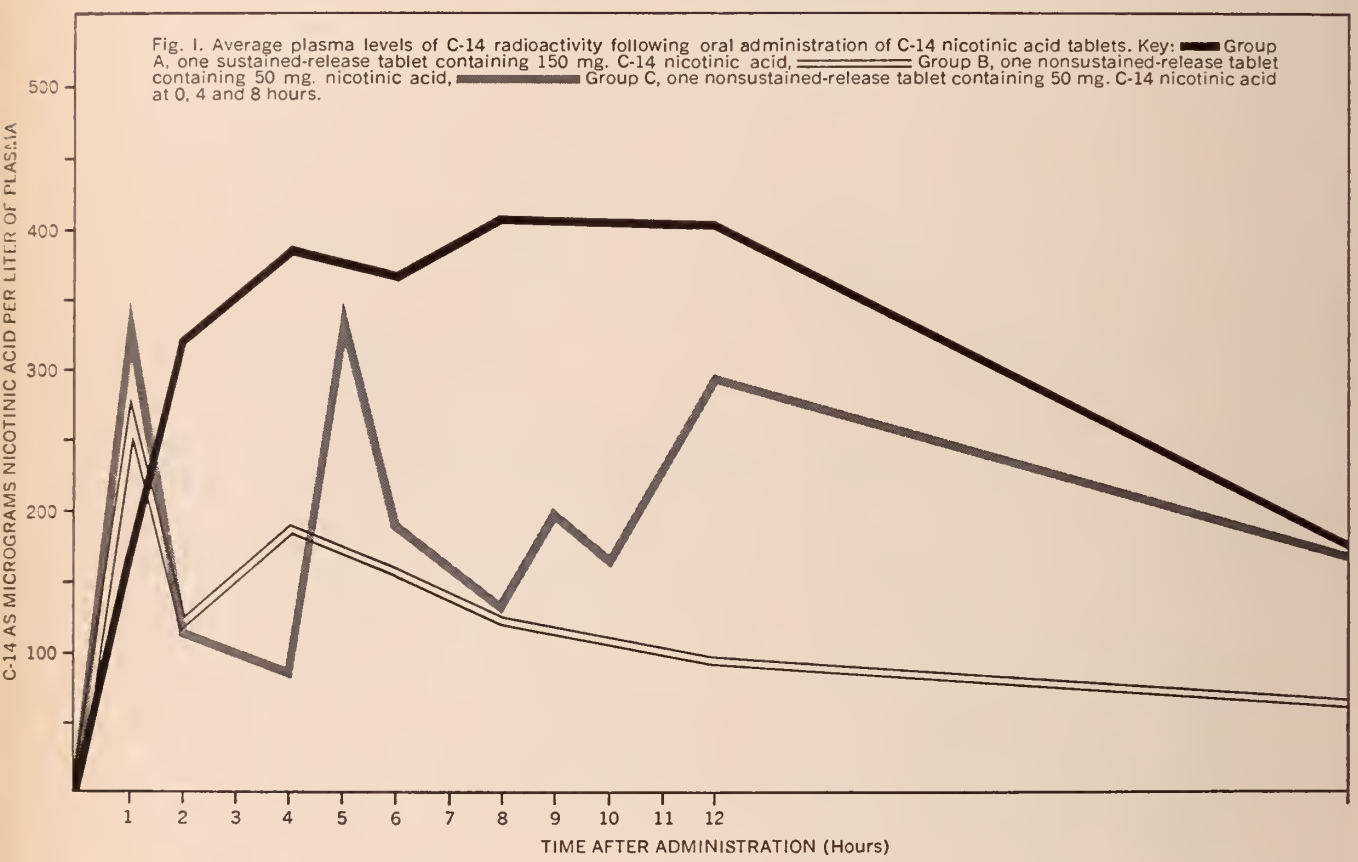
This time it'll be different. Emetrol taken before the trip begins will usually prevent nausea and vomiting. Emetrol is effective and safe...most helpful where safety is most important. It acts locally—not systemically.

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate solution
emesis control

Sustained circulatory, respiratory and cerebral stimulation for the





(fewer absent doses by absent-minded patients)

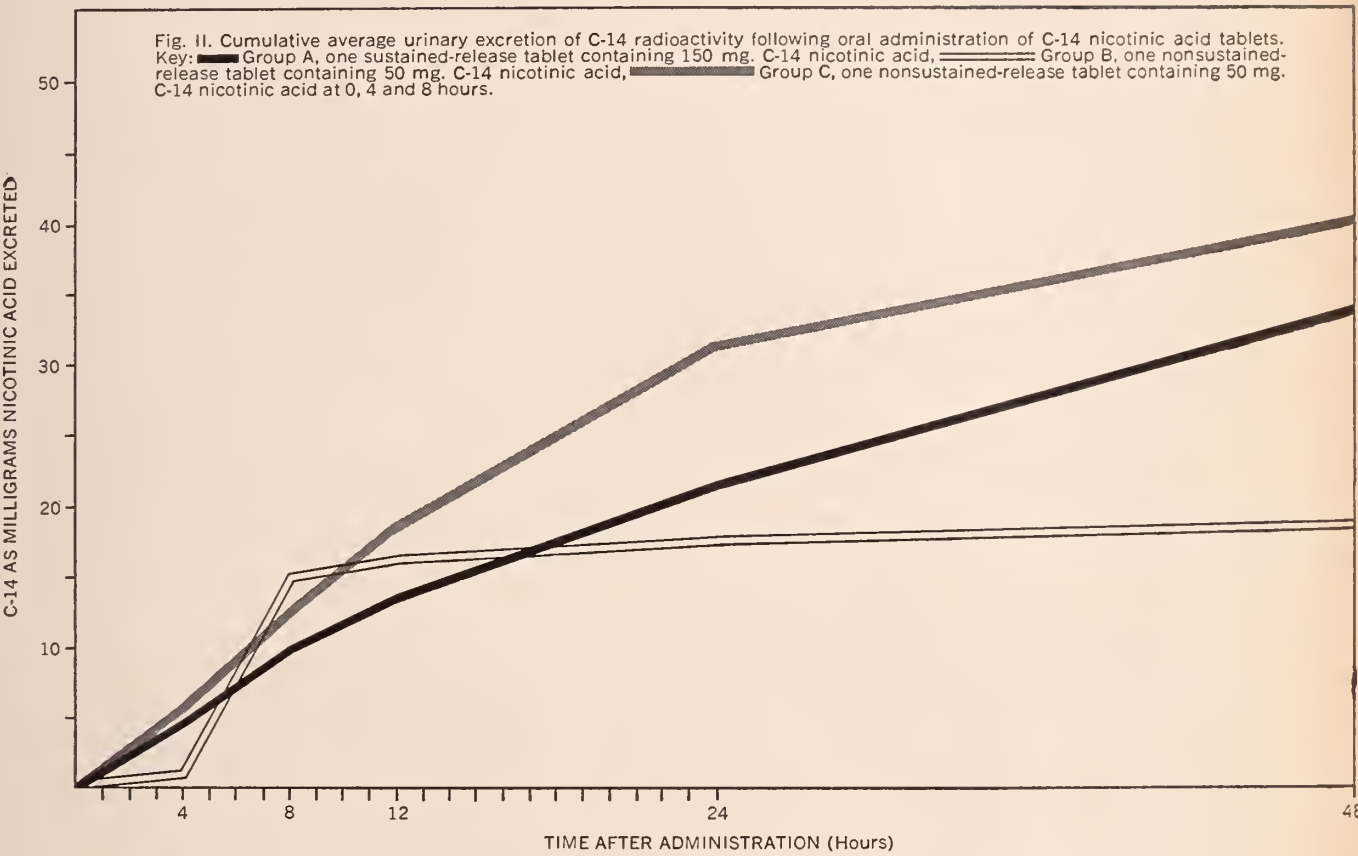
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol® TT
nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

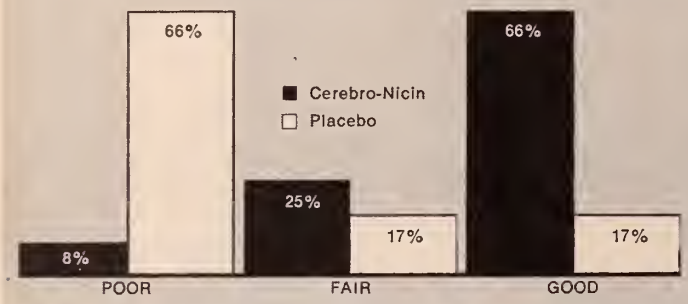
For the treatment of the aging patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
1-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

Write for literature and samples...

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057
Write for Product Catalog

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY
ANDROID — GOOD TO EXCELLENT 75%
PLACEBO — 20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**also available with ESTROGEN*

Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg.
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE.** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS:** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android

Each yellow tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP

HIGH POTENCY

Each red tablet contains:

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:

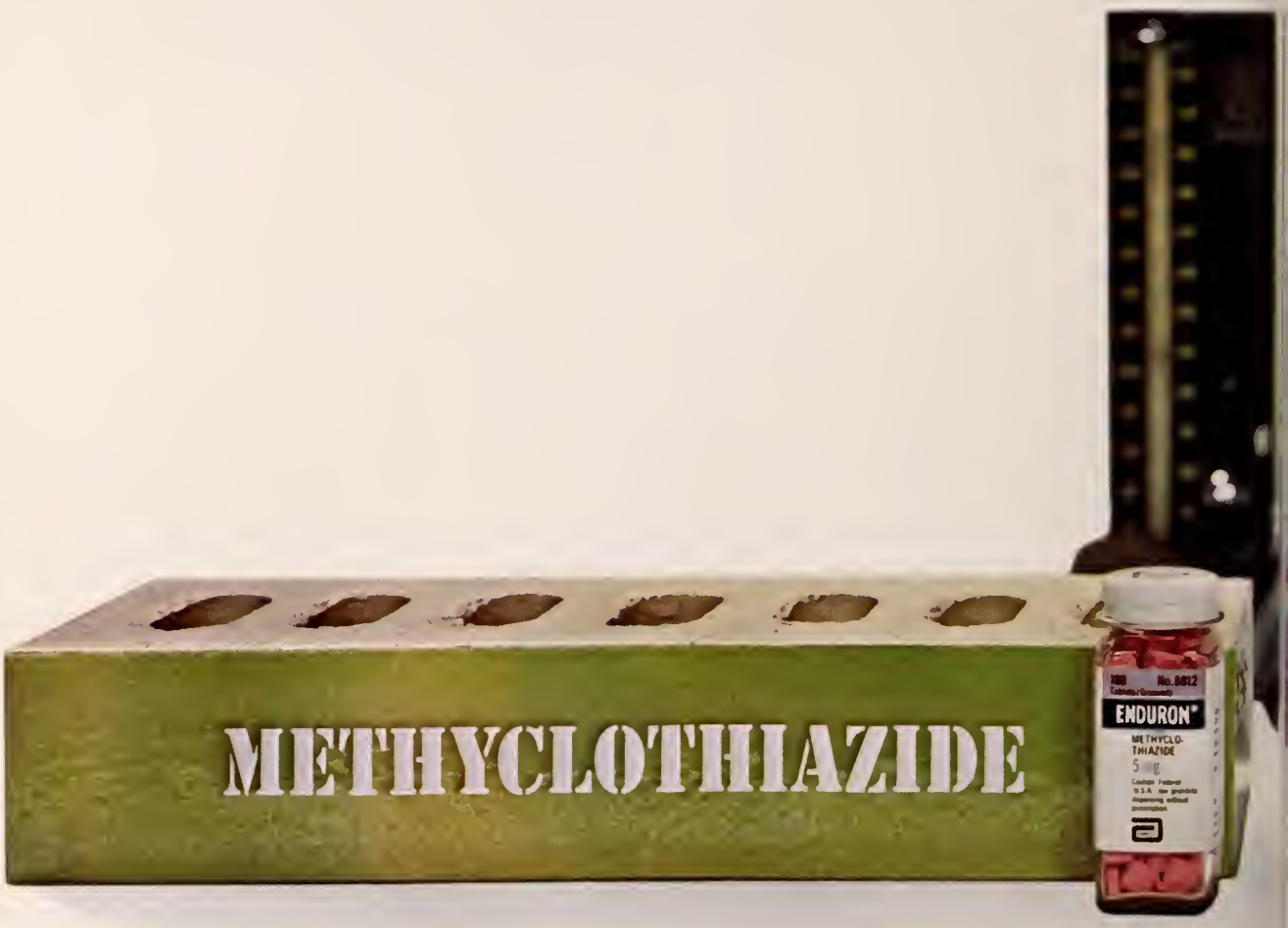
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

Abbott Antihypertensive Building Blocks

A simplified approach to the practical management of hypertension



Enduron: (methyclothiazide) A basic building block for mild hypertensives



Excellent day-long Na^+ output, yet easy on the K^+

Enduron provides an excellent starting therapy. Your patient's sodium excretion is greatly enhanced. Yet potassium loss is low.

The therapeutic action is smooth, and persists for a full 24 hours. With Enduron you can prescribe convenient once-a-day dosage without skimping your patients on day-long thiazide effectiveness.

Of course, as with all thiazides, supplemental dietary potassium should also be considered.

Use Enduron as a basic therapy in patients with mild to moderate hypertension. A single 5-mg. tablet each day is ample in most cases.

Once a day, every day

ENDURON

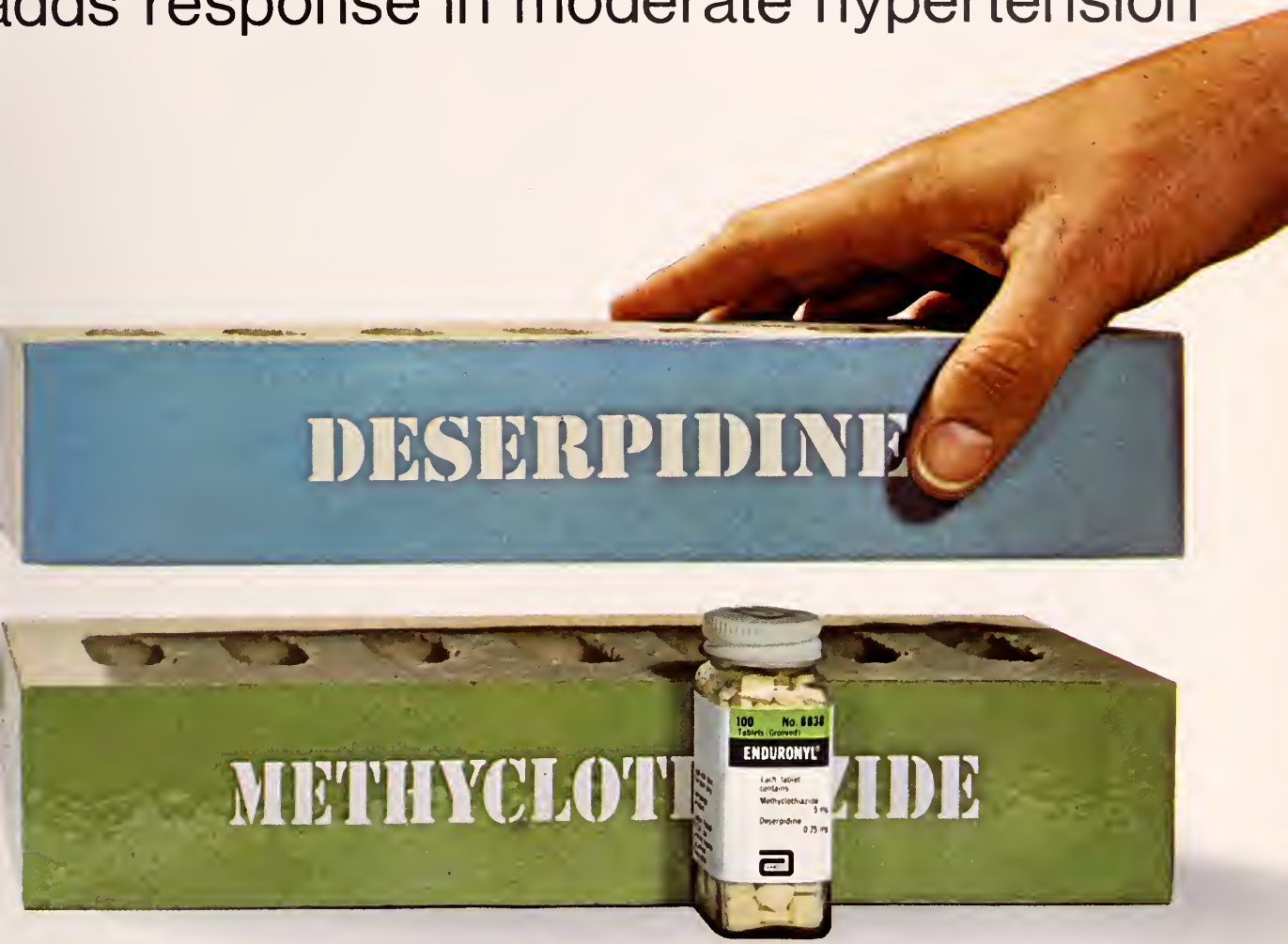
METHYCLOTHIAZIDE

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

Enduronyl: Its deserpidine component adds response in moderate hypertension



Less frequent rauwolfia side effects than with reserpine

When you wish to build further response, consider shifting to Enduronyl.

Enduronyl adds a building block of *deserpidine*. This is a purified rauwolfia alkaloid available only from Abbott. It adds good antihypertensive and tranquilizing activity. Yet its incidence of untoward effects, particularly lethargy and depression, is lower than with reserpine.

Enduronyl is available plain or Forte. The latter provides its variation where most helpful, by doubling the deserpidine.

Use Enduronyl for patients throughout the broad range of mild to moderately severe hypertension.

Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 mg. with RESERPIDINE 0.25 mg. or (FORTE) 0.5 mg.

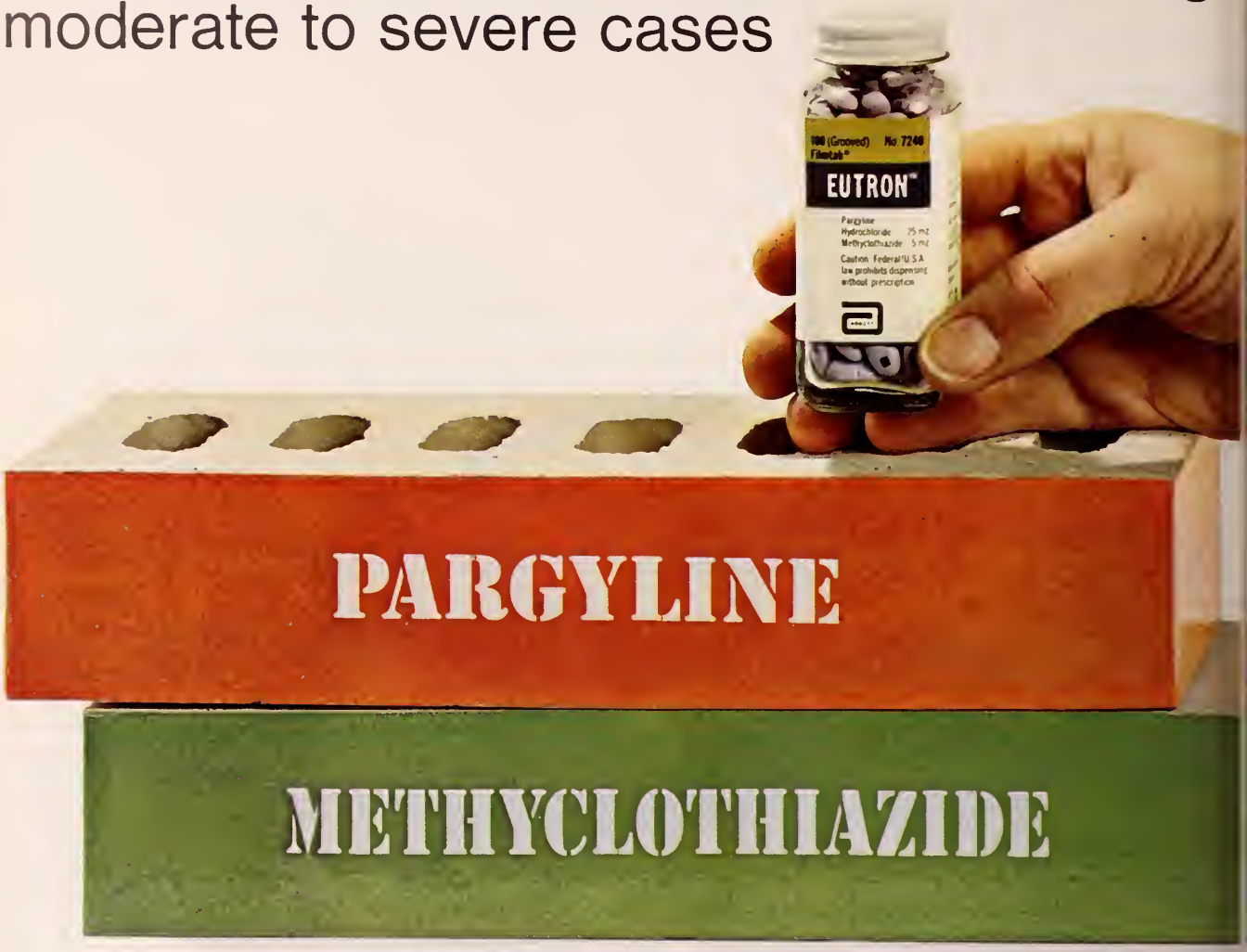
MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

Eutron: A unique combination for handling moderate to severe cases



Affords almost uniform diastolic reduction in all body positions

Eutron lowers diastolic pressures nearly equally, whether your patient is standing up or lying down.

Thus, in clinical trials, average *standing* diastolic readings were reduced from 112 pre-treatment to 90 post-treatment; *sitting* from 115 to 95; and *recumbent* from 112 to 94.

Note that following Eutron, the diastolic reductions were nearly alike in all three body positions.

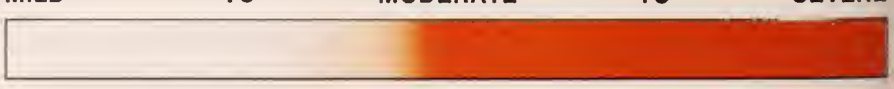
Use Eutron for managing your moderate to severe cases. Its building blocks enhance each other; hence lesser doses often suffice.

Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 mg.
with METHYCLOTHIAZIDE 5 mg.

MILD TO MODERATE TO SEVERE



See Brief Summary on final page of advertisement

801094

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains Methyclothiazide 5 mg. with Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symtomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON™

Each tablet contains Pargyline Hydrochloride 25 mg. with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhibitors; methyldopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage; caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions—Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficult in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug. 804438R

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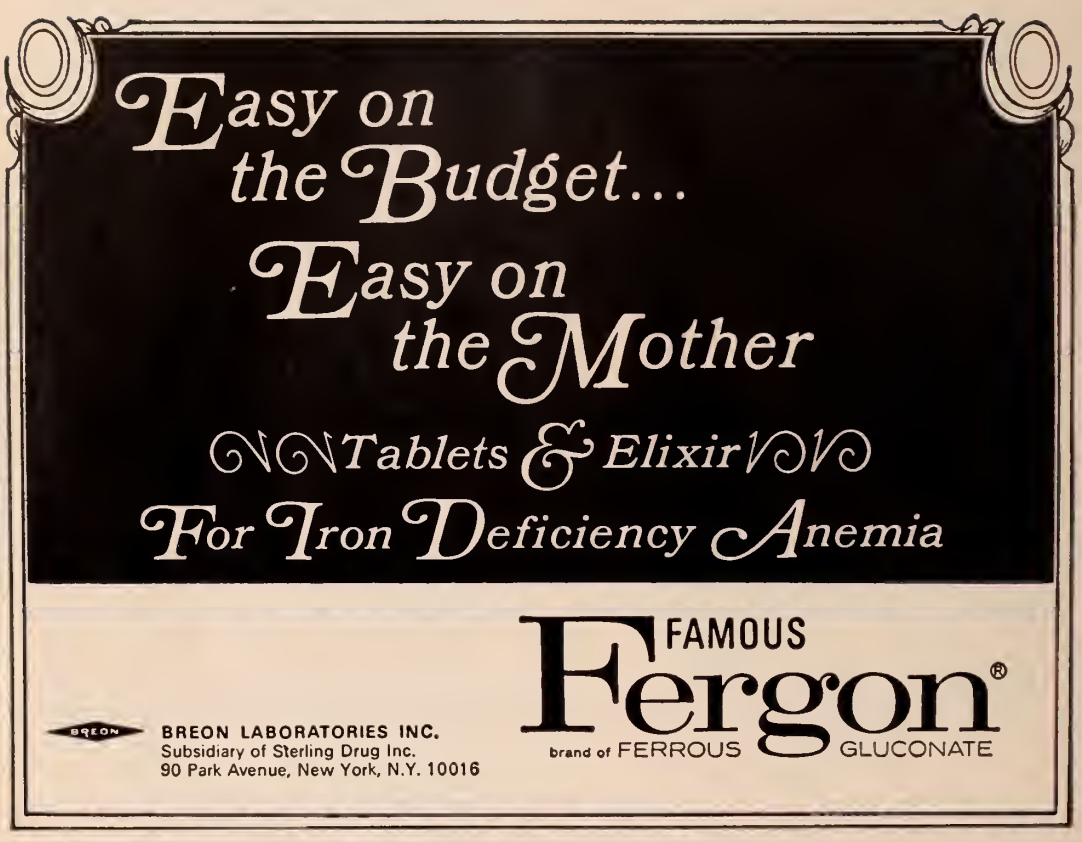
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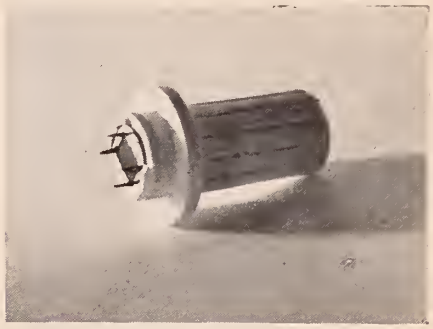
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Additional

Personnel

see 31A

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindications: Known hypersensitivity to drug; children under 6 months of age; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in treatment of psychotic patients, and should not be employed in lieu of appropriate treatment. As with most CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may also be associated with temporary increase in frequency and/or severity of seizures. Advise patients against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance. Keep addiction-prone individuals (such as drug addicts or alcoholics) under careful surveillance because of their predisposition to habituation and dependence. Use of any drug in pregnancy, lactation or in women of childbearing age requires that potential benefit be weighed against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants. Employ usual precautions in the severely depressed or in those with latent depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautior impaired renal or hepatic function. Limit dosage to sma effective amount in elderly and debilitated to preclude at or oversedation (initially 2 to 2½ mg once or twice daily, creasing gradually as needed or tolerated).

Adverse Reactions: Side effects most commonly repor drowsiness, fatigue and ataxia. Infrequently encountered: fusion, constipation, depression, diplopia, dysarthria, heada hypotension, incontinence, jaundice, changes in libido, nau changes in salivation, skin rash, slurred speech, tremor, urii retention, vertigo and blurred vision. Paradoxical react such as acute hyperexcited states, anxiety, hallucinations creased muscle spasticity, insomnia, rage, sleep disturba and stimulation have been reported; should these occur, us the drug should be discontinued. Because of isolated reports ... neutropenia and jaundice, periodic blood counts and liver function tests are advisable during long-term therapy. Minor changes in EEG patterns (low-voltage fast activity) observed during and after therapy and are of no known significance.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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